# OTTR™ 6
# User Manual

August 2012

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## How to Login to OTTR™

It's important to remember NEVER to share your login information. Everything in OTTR™ is tracked with your login account. Anything that is documented or accessed within OTTR™ using your username will appear as though it was done by YOU.

Double-click on the OTTR™ Patient Tracking System Icon on your desktop.

Your login window will appear.

OTTR
OTTR Edit Lists Patient Add Tools Windows Help
CHRONIC CARE SOLUTIONS
TRANSPLANT CARE PLATFORM
Username
Password
Server dbs3::qa6
Vendor SQL Server
Login
Always use this database
Login Automatically Using Windows
You are about to connect to the OTTR Patient Tracking Database. Unauthorized use is prohibited. Please exit immediately if you are not authorized to be on this system.
OTTR 6

• **Username:** Enter your assigned username

• **Password:** Enter your assigned password

• **Server:** This should be pre-populated for you. You may be given instructions to change this at some point. For example, if you're in a TEST (testing) environment and need to be in a PROD (live or production) environment or vice versa.

• **Vendor:** This should also be pre-populated. If it's not, please see your OTTR™ Administrator.

• **Always use this database:** This option can be selected if you wish to store the Server information for subsequent logins.

• **Login Automatically Using Windows:** If your site has opted to use Active Directory, this option should be selected. Do not select this if you are unsure or if your site doesn't intend to use Active Directory.


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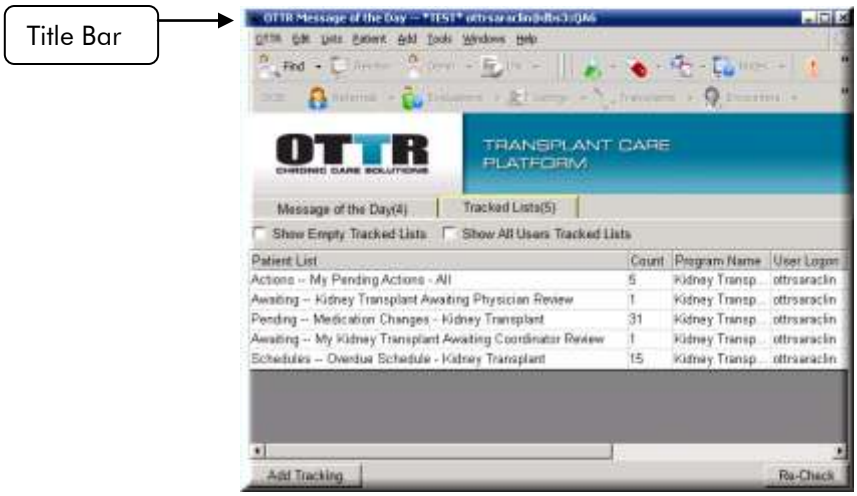
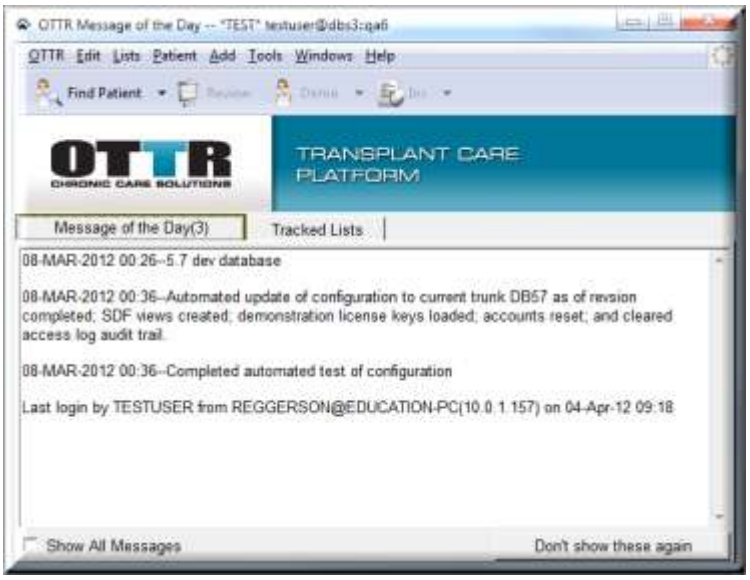



Once you've successfully logged into the OTTR™ application, the window titled **OTTR™ Message of the Day** will display. The Title Bar displays the title of the window, indicates if you are in a Test or Production environment, the name of the logged in user, and the database information.

There are 2 tabs in the **OTTR Message of the Day** window; **Message of the Day** and **Tracked Lists**. Tracked Lists help you manage your daily workflow and allow easy access to Lists that you frequently use such as the *My Pending Actions* list.


OTTR Edit Lists Patient Add Tools Windows Help
Find Patient
TRANSPLANT CARE PLATFORM
Message of the Day(3)
Tracked Lists
08-MAR-2012 00:26--5.7 dev database
08-MAR-2012 00:36--Automated update of configuration to current trunk DB57 as of revsion completed; SDF views created; demonstration license keys loaded; accounts reset; and cleared access log audit trail.
08-MAR-2012 00:36--Completed automated test of configuration
Last login by TESTUSER from REGGERSON@EDUCATION-PC(10.0.1.157) on 04-Apr-12 09:18
Show All Messages
Don't show these again

Click on the **Message of the Day** tab to view messages that your OTTR™ Administrator wishes to communicate with you; such as scheduled downtimes, system issues, words of wisdom, etc. If you've viewed the Message of the Day and don't wish to see it again, select the **Don't show these again** option. To view the messages again, click the **Show All Messages** option.

***Note:** The last login information will always display in the **Message of the Day** tab and can't be cleared. It shows the last login information with the date/timestamp.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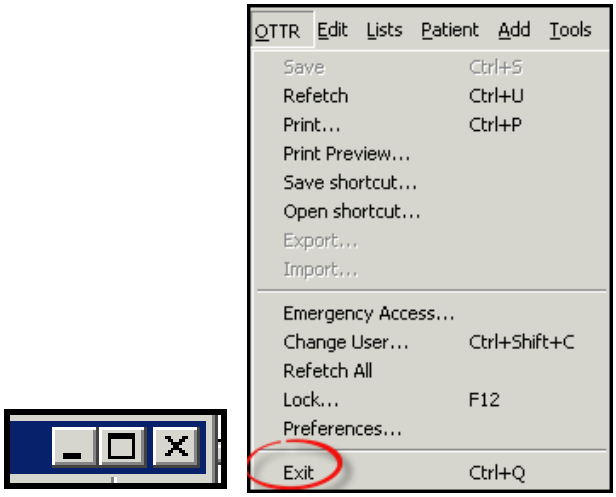
# General OTTR™ Functionality

Outlined below are some basic principles and tips for navigating through the OTTR™ application.

## Exiting




At the top of each window you have the option to minimize, maximize or close (exit) the window. If you're exiting the application completely, remember to use the **OTTR** Master Menu and select **Exit**.

At the bottom of most windows the options exist to:

**Delete** - Click to delete the entry from view.

**Revert** - Click to revert back to the original window prior to any entry being made. This will remove any newly entered information that hasn't been saved.

**Close** - Click to exit or close the window without saving.

**Save** - Click to save your information and remain working in the open window.

**Save & Close** - Click to save your information and close the current window.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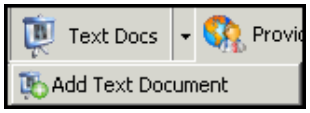
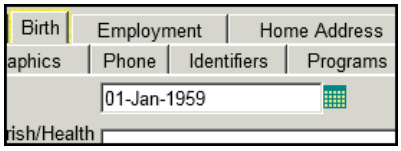
# Navigating

**Icons** - 

Click on an icon to access that area of the chart or select another option using the dropdown arrow next to the icon .

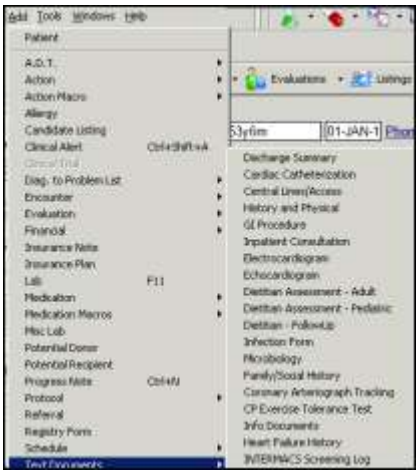
**Hyperlinks** -

Click on a hyperlink to directly access where that information is entered.




**Buttons** -

Much like the icons, you can click a button to access that area.

**Master Menu** - 
Utilize the master menu to display options in a menu form.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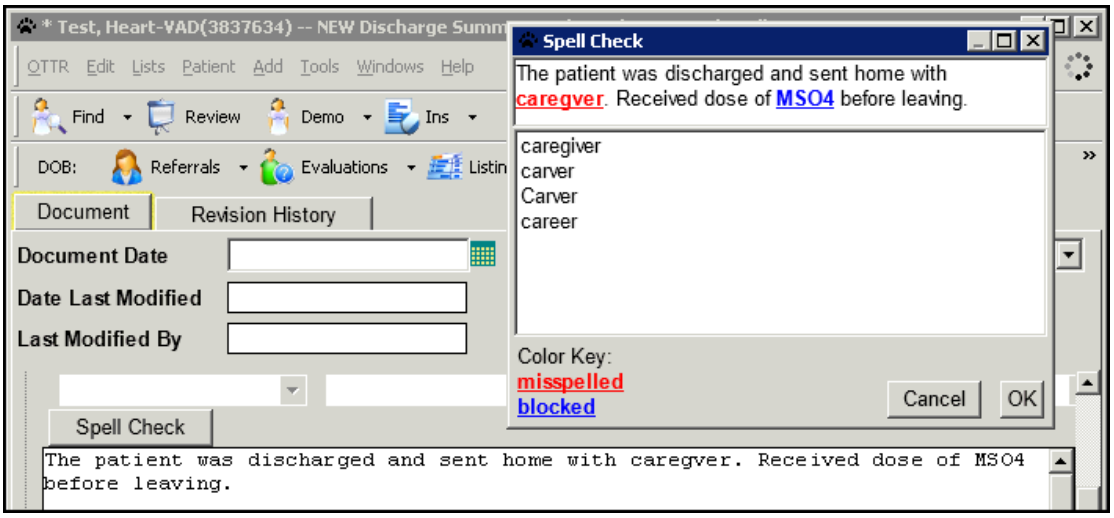
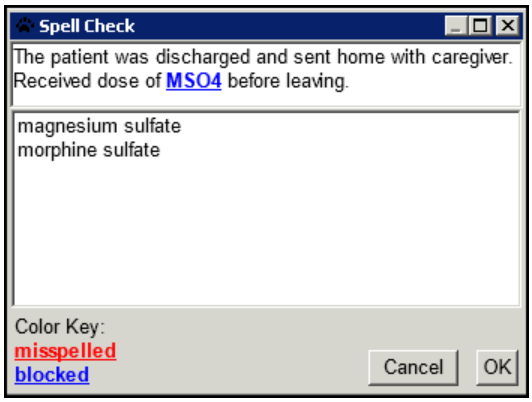
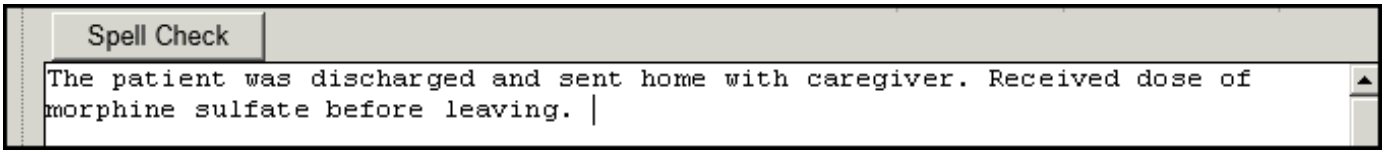
# Spell Check




In areas such as Progress Notes and Text Documents there is now a **Spell Check** option. After typing your entry, click the **Spell Check** button to reveal blocked or misspelled words. Click on the misspelled or blocked in the top of the window to find alternate spellings or words. Select the correct alternative, then **OK.** Corrections will be reflected in the window.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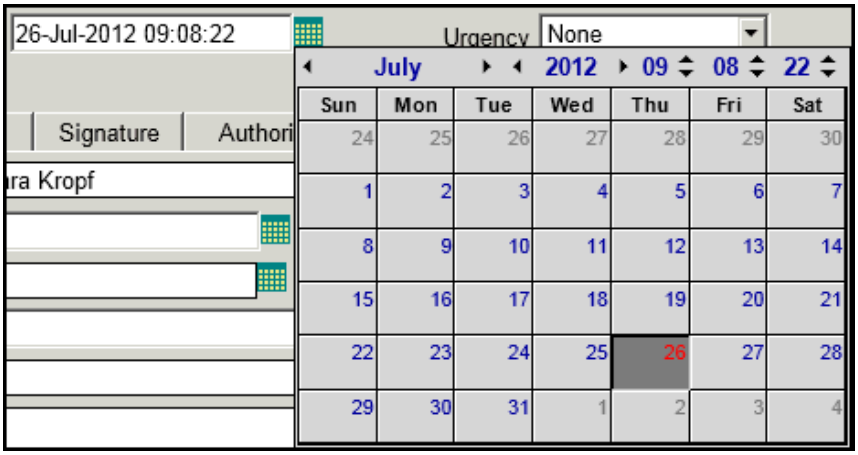
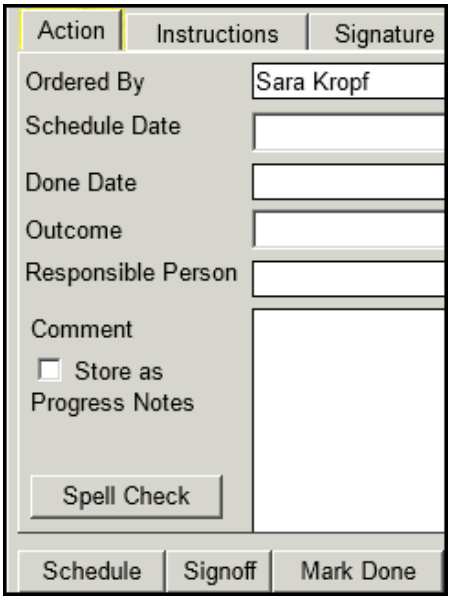
## Entering Dates

Most date fields will auto-populate with "today's" date and time. The date can be manually entered using mm/dd/yy format or +(x days) , - (x days). You can also place your cursor inside the date field and manually make your correction.




If you want to utilize the green calendar, click on the date in the calendar to change, or use the forward and backward arrows. The up and down arrows can be used to modify the time.




If you're working in an action window, you first have to click the **Schedule** button and the **Mark Done** button to activate those respective date fields.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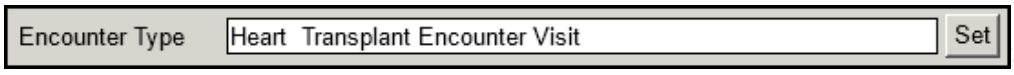
## Fields

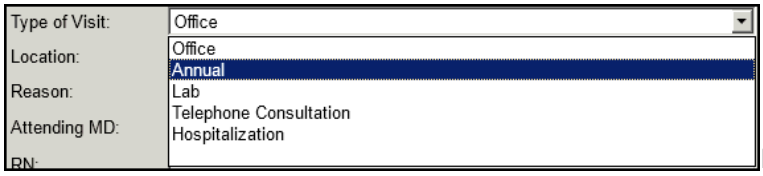
**Free Text** -

Fields with no dropdown arrow or action buttons after the field will accept free text.

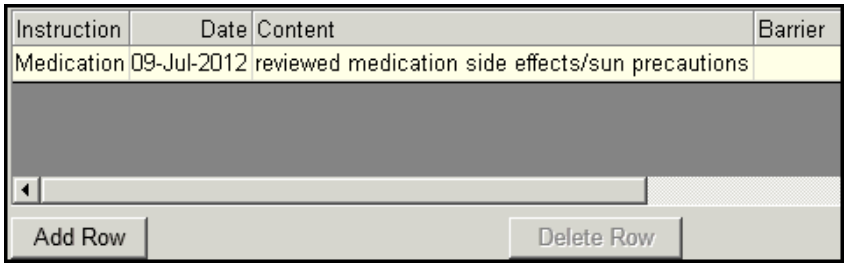
**Search** - 

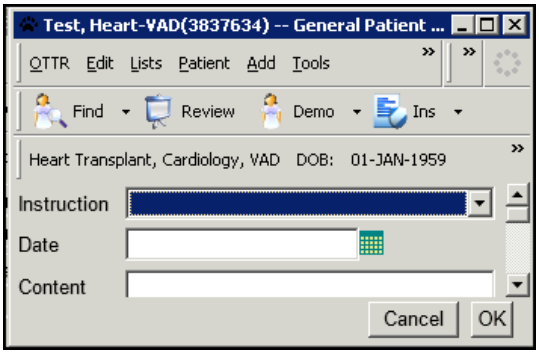
elds with a Set button, Pick button, or a Change button

don't allow free text. Instead, you must click on the button and search for the appropriate option.

**Dropdown** - 

Fields with a dropdown arrow don't allow free text. Instead, you must click on the arrow and select from the list provided.




**Add Row** - Click the Add Row button which opens a new window allowing you to enter information. When finished, click OK and your information is saved and displayed in row and column format.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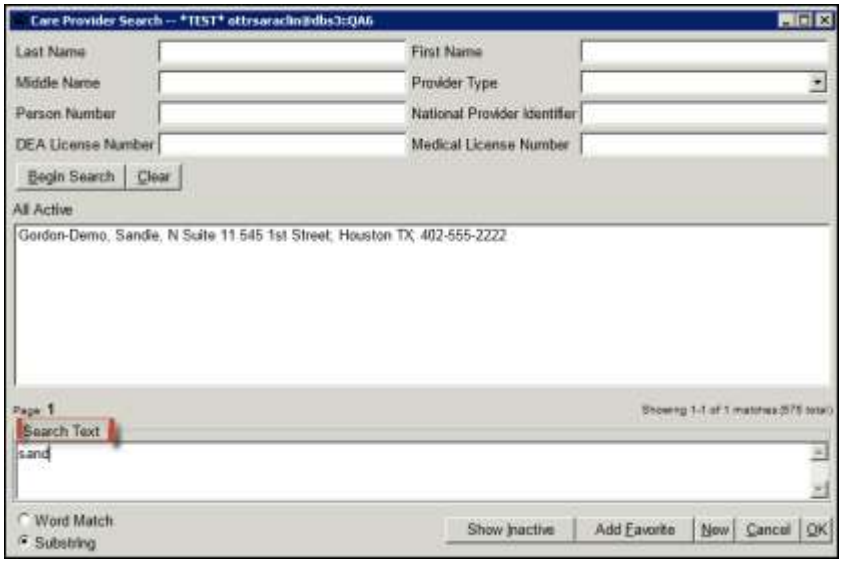
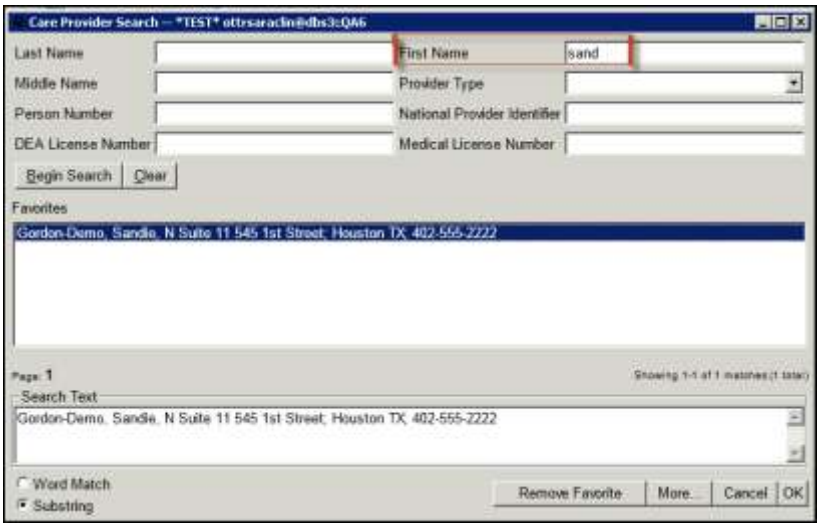
# Searching




Searches can be initiated by starting to type part first or last name or word, in the case of medications and diagnoses, into the **Search Text** area. The application will return possible matches in the **All Active** box. Select your choice by highlighting the row and click "OK" or just double click.

Searches can also be initiated by typing into the fields at the top of the window such as first or last name. Click the **Begin Search** button and options will be returned below. Select your choice by highlighting the row and click "OK" or just double click.

If you don't find what you're looking for on the initial search, you can try selecting the **More** button in the bottom of the window, then re-initiate your search.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## Refetch

If you've made a change or entry and don't see it immediately available, you can select the **Refetch** option in the **OTTR** Master Menu for a quick refresh.


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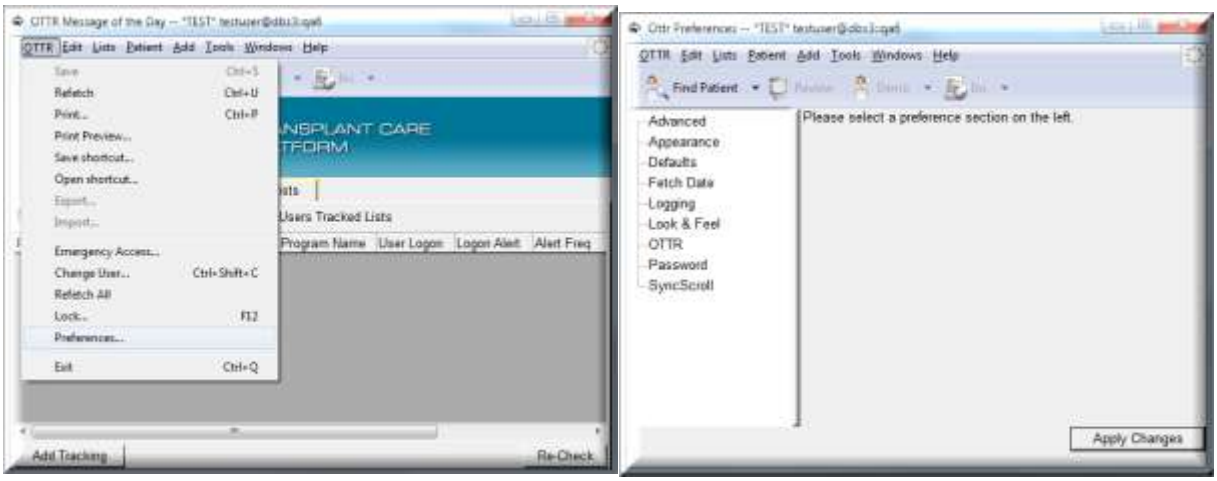
# Initial Setup

This section explains the steps you'll complete after your initial login to OTTR™. It defines the one-time setup preferences each user should complete.

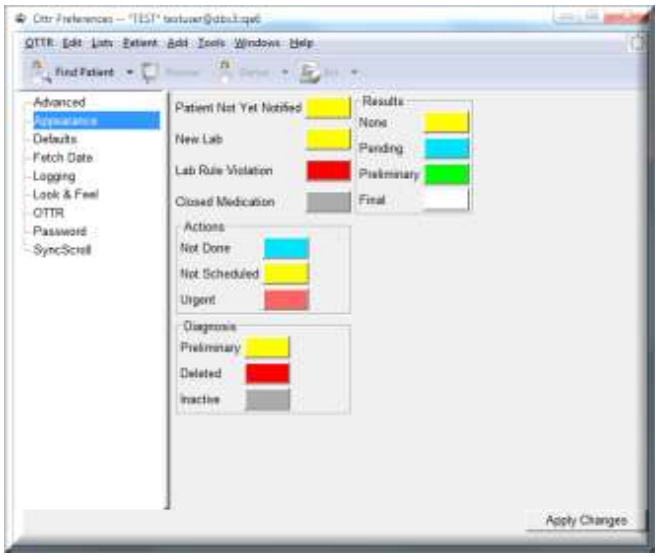
## Setting Preferences

To define on-time individual preferences, click the OTTR Master Menu option and then select **Preferences**.




## Appearance

Select the **Appearance** option. Colors allow you to understand the status of labs, medications, actions and diagnosis. It is important that these colors NOT be changed.





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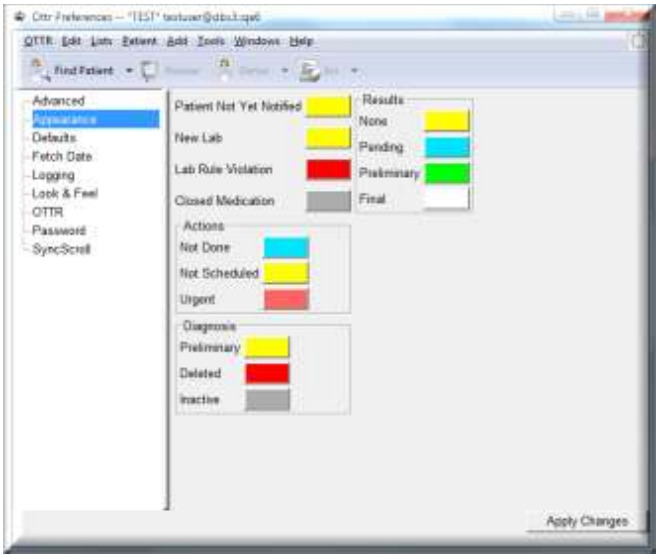


**Patient Not Yet Notified:** This color displays when a medication is modified or added to a patient's record and the patient hasn't been marked as notified of the change.

**New Lab:** This color displays when new labs have either been manually entered or have come over the Automated Interface.

**Lab Rule Violation:** This color displays when a lab result violates a lab rule that has been set in the database. * The OTTR™ Administrator has the ability to set lab rules.

**Closed Medication:** This color displays if a medication has been discontinued or ended.

**Actions – Not Scheduled:** This color displays when an action has been entered on a patient's record but has not been scheduled.

**Actions – Not Done:** This color displays when an action has been entered on a patient's record, has been scheduled, but not marked done.

**Actions – Urgent:** This color displays when an action has been entered on a patient's record and the Urgency Level has been marked as Urgent.

**Diagnosis – Preliminary:** This color displays when a diagnosis has been entered on a patient's record and has not been marked as confirmed.

**Diagnosis – Deleted (Verified Negative):** This color displays when a diagnosis has been entered on a patient's record and then verified negative. For example, a diagnosis was entered and later found to be an inaccurate or incorrect diagnosis, it would be marked as Verified Negative.


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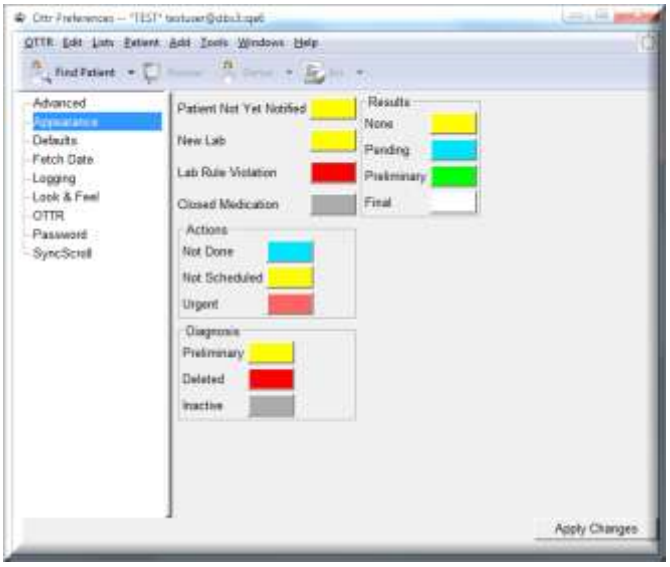


**Diagnosis – Inactive:** This color displays when a diagnosis has been entered on a patient's record and marked as Inactive. For example, a patient was treated for pneumonia that is now resolved and no longer an active problem.

**(Interface) Results – None:** This color displays when a lab result has come over the interface and has not been reviewed.

**(Interface) Results – Pending:** This color displays when a lab result has come over the interface indicating that the result is pending.

**(Interface) Results – Preliminary:** This color displays when a lab result has come over the interface indicating that the result is preliminary.

**(Interface) Results – Final:** This color will display when a lab result has come over the interface indicating that the result is pending.


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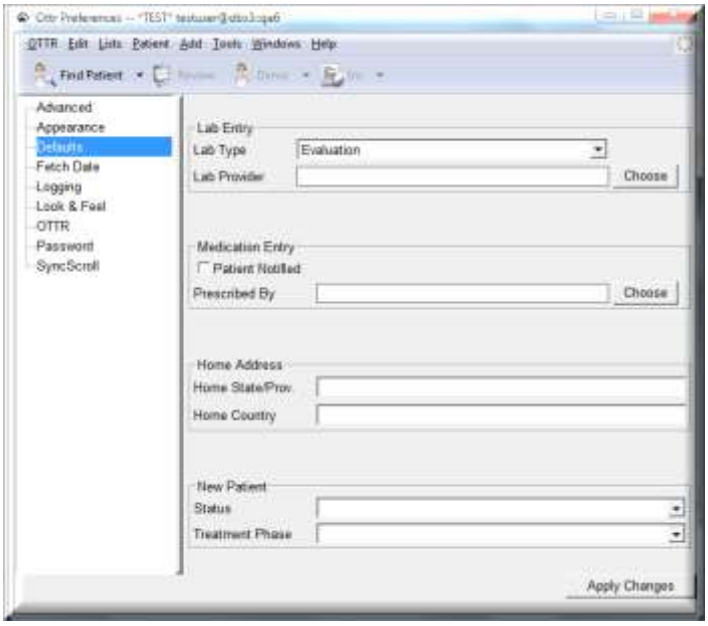
## Defaults

Select the Defaults option. You have the ability to set default options for Manual Lab Entry, Medication Entry, Home Address State/Province/Country, and New Patient Status/Treatment Phase.




**Lab Entry – Lab Type:** For manual lab entry, you can set the default lab type (Evaluation, Inpatient, Outpatient, Inpatient Elsewhere, etc) *Lab Types can be added/modified by the OTTR™ Administrator.

**Lab Entry – Lab Provider:** For manual lab entry, you can set the default Lab Provider.

**Medication Entry – Patient Notified:** You can default all of your manually entered medications to be marked as Patient Notified which indicates that the patient is aware of the new or adjusted medication. *Recommended practice is to leave this **unchecked** for patient safety reasons.

**Medication Entry – Prescribed By:** You can decide to have all of you manually entered medications to be prescribed by one physician.

**Home Address – Home State/Prov.:** If all of your patients entered into OTTR™ are from a particular state, you can have this state/province set as a default.

**Home Address – Home Country:** If all of your patients entered into OTTR™ are from a particular country, you can have this country set as a default.

**New Patient – Status:** You can set a default Patient Status for new patients entered into OTTR™. For example, if most of your patients enter your center as an outpatient, you can select the option of Outpatient.

**New Patient – Treatment Phase:** You can set a default Treatment Phase for new patients entered into OTTR™. For example, if most of your patients enter your center as a new referral, you can select the option of Referral.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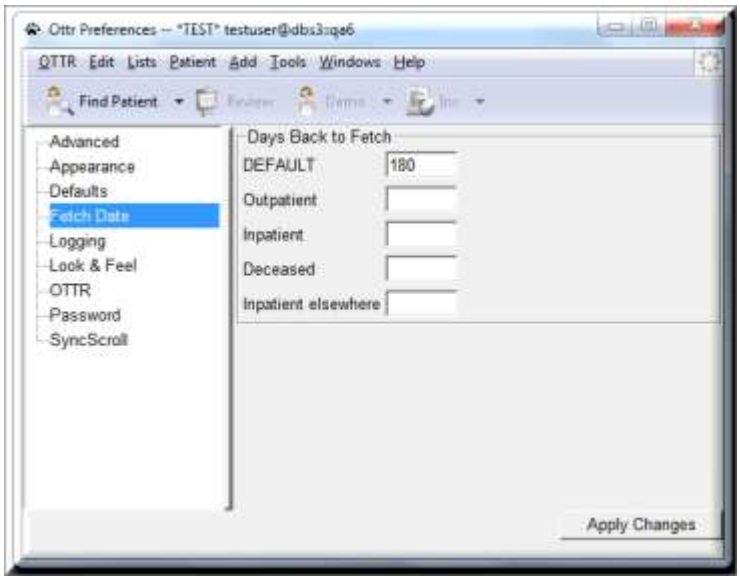
## Fetch Date

Select the **Fetch Date** option. The concept of 'fetch' is to retrieve data. In the OTTR™ Master Menu, your options for **Refetch** and **Refetch All** follow the same concept. In Preferences, you can decide how many days back you would like OTTR™ to 'fetch' patient data. We have it automatically defaulted to a recommended 180 days so if this is not adjusted, OTTR™ will 'fetch' 180 days of patient data from the current date. When working in the patient record, you'll also have the ability to change the number of **Days Back to Fetch** in some of the individual OTTR™ windows such as labs.




**Default:** This represents the default patient status that OTTR™ will adhere to for records to 'fetch'.

**Outpatient/Inpatient/Deceased/Inpatient elsewhere:** This represents the status that OTTR™ will adhere to if you have set days for a patient with this patient status.

***Note:** One thing to remember about this is if you extend the number of days and a patient has a lot of data (Labs, Actions, etc) this may take a longer time to pull up the Patient Review Screen.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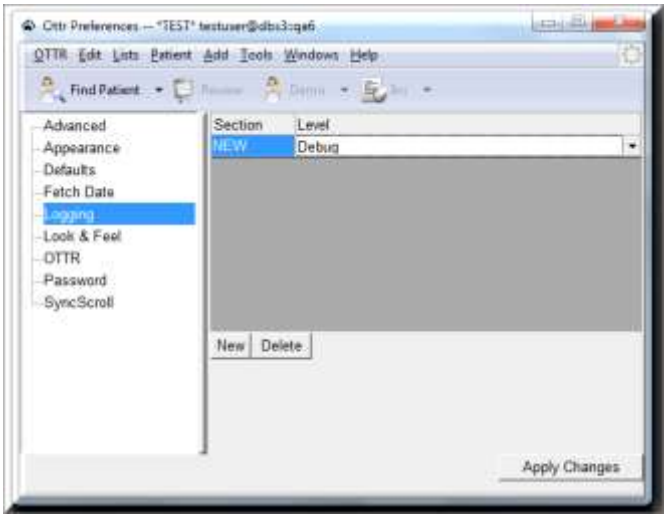
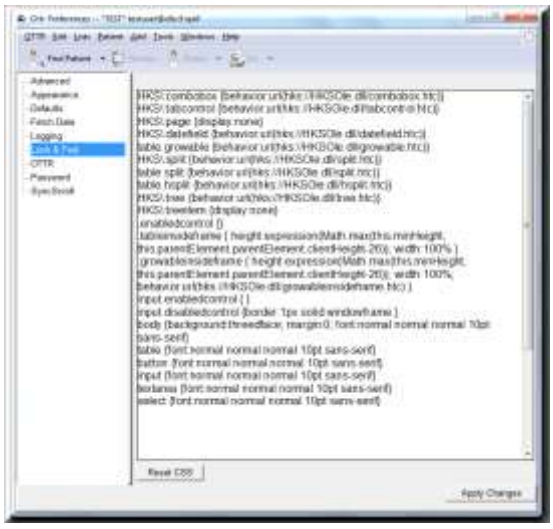
## Logging




This area is designed for OTTR™ Administrators who are working with the Vendor to troubleshoot issues (locking, database errors, getting kicked out of OTTR™, etc.) that have been reported and need further investigation. Setting this option will allow OTTR™ to send the SQL output to the Event Log so that OTTR™ can see what commands could possibly be causing the issue.

*Note: There is no need to visit this area for preferences setting.

## Look and Feel



This area is designed for configuration only. It should only be accessed by the OTTR™ Administrator. If at any time you are able to view this area, please let your OTTR™ Administrator know and DO NOT make any modifications.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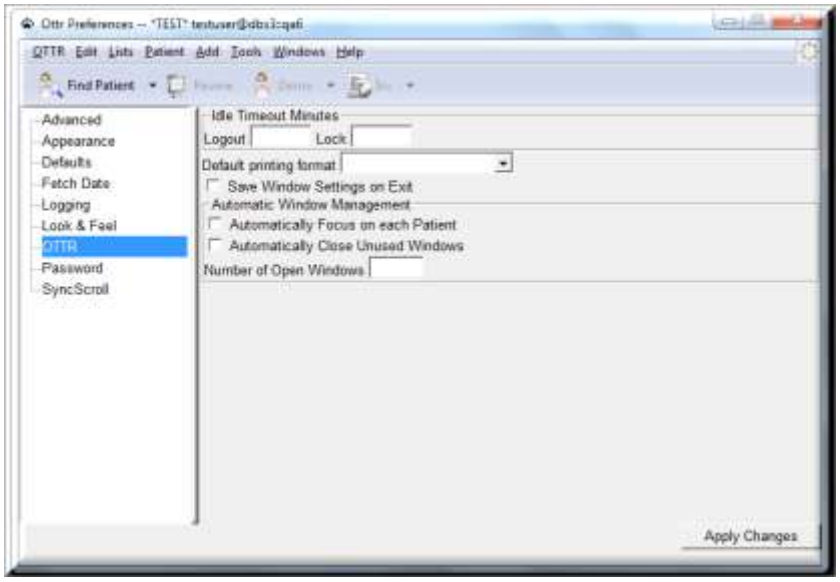
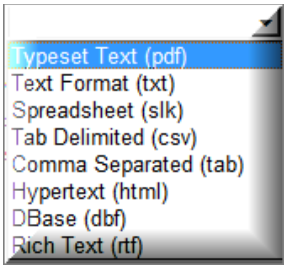
## OTTR

**Idle Timeout Minutes** -Your OTTR™ Administrator will have this set in the back end to be compliant with your hospital's regulations. You cannot lengthen this time beyond what has been set for the database but you can shorten it if you prefer.

For example, if the hospital standard is to Logout after 15 minutes of idle time and Lock after 10 minutes of idle time, you can adjust your single preference to be 10 minutes for Logout and 5 for Lock.




**Default printing format -** You may set the Default printing format so that when you select the print option; OTTR™ will send it to the format selected. These are your options:




**Save Window Settings on Exit:** This preference will allow OTTR™ to remember your window sizes and splitters. If you are kicked out of OTTR™ unexpectedly, OTTR™ will also remember the windows you had open and will bring them back up when you log in again.

***Note:** One thing to remember about this is if you are using multiple workstations and the resolutions are different this can impact your OTTR™ screen sizes. If at any time you are having issues with your window sizes (grey screens, missing hyperlinks, etc) please see your OTTR™ Administrator.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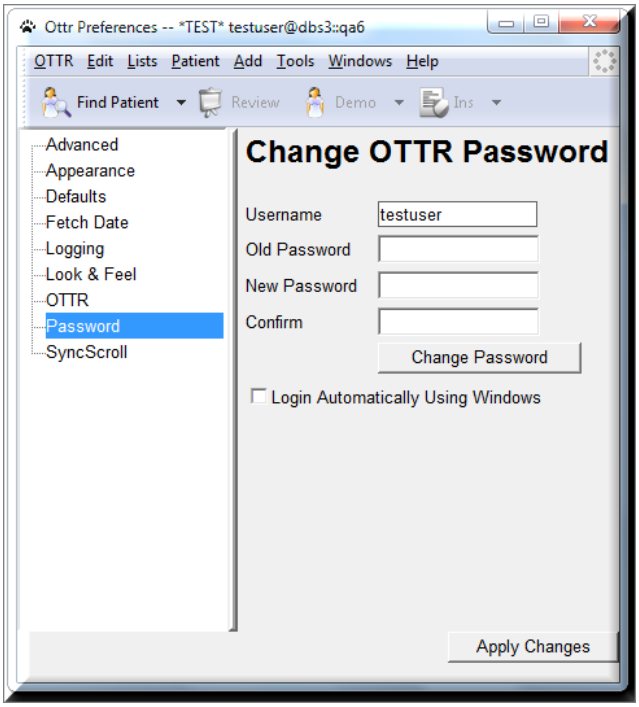
## Password change




You can change your password at any time by selecting the Password option in Preferences.

**Old Password:** Enter your current password here.

**New Password:** Enter your new password here.

**Confirm:** Enter your new password again to confirm.

When completed, select the **Change Password** option.

**Login Automatically Using Windows:** This option is for sites using Active Directory to log into OTTR™. OTTR™ uses your Windows login to sign into OTTR™. DO NOT select this option if your site does not have Active Directory set up or if you are unsure.

***Note:** Best practice is to change your OTTR™ login whenever your network login requires a new password to be created. This ensures that you are compliant with the hospital's established password policy.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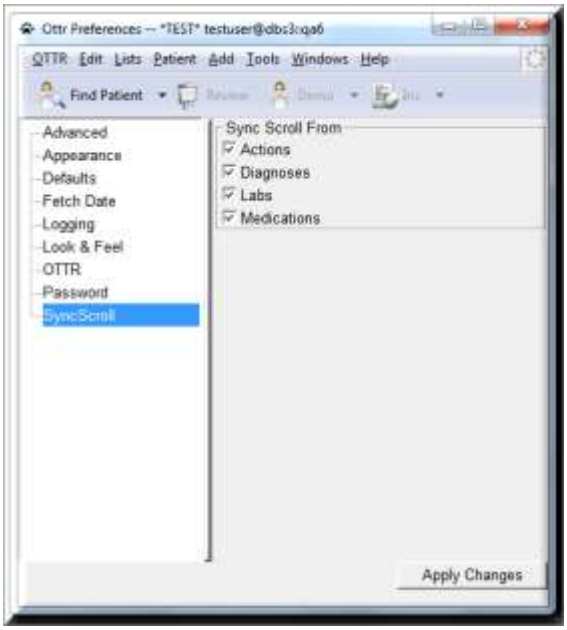
## SyncScroll

All of these options should be default checked. In the patient review screen when you highlight an option such as a lab, OTTR™ will display the remaining options (actions, diagnosis, medications) closest to the date and time of the highlighted item. It provides a snapshot of the care given at that time.





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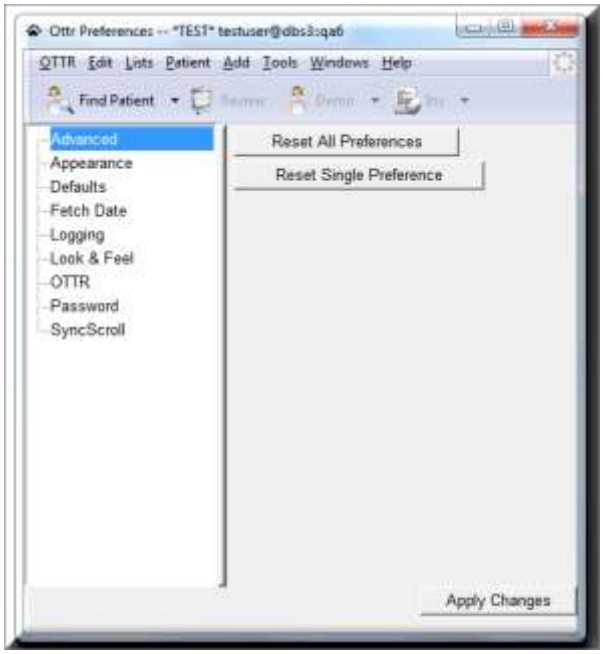
# Advanced




In the event you are experiencing issues with your window sizes, you can use the **Advanced** option to reset your Preferences.

**Reset All Preferences:** This will reset all of your preferences and revert them back to the standard.

**Reset Single Preference:** This option will allow you to select a preference to reset. In the example of having window/splitter issues, you may want to reset the single preference for window sizing.

Once you've set all of your preferences, select **Apply Changes** and close this window using the in the upper right of the window.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# Toolbars, Icons, and Master Menus

This section explains how to set up your Toolbars which have certain icons that will allow for easier access to areas of the patient's record. This section will also cover the Master Menus and the items within each menu so that you can be aware of other areas available to you that may not be accessible from an icon.

Toolbars contain icons that allow access to specific areas of the patient's record with a single click. Based on the role/s you may have, you'll want to have certain toolbars. The standard toolbar displays icons with titles. There is an **Icon Only** option that does not give a description for the icon

The three main toolbars are:

**Basic:** Support icons

**Clinical:** Patient charting icons

**Solid Organ Tx:** Workflow icons

To activate your Toolbars, select the **Windows** Master Menu option. From Windows, select the **Toolbars** option. Notice that your Basic Toolbar is already checked for you. Proceed with selecting the Clinical Toolbar.

***Note:** Notice that this will close the menu so you will need to go back in and add the other applicable toolbars (Solid Organ Tx)

*Your OTTR Administrator has the ability to create new Toolbars and also modify existing Toolbars to accommodate your needs.


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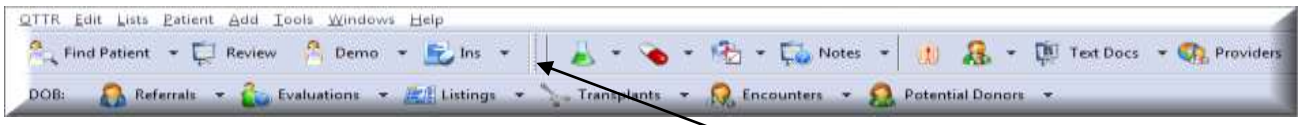
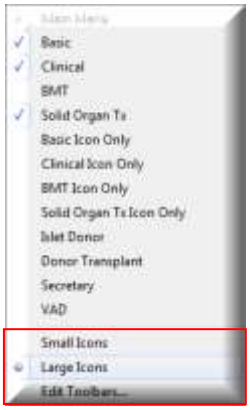



To save space, utilize the drag and drop feature to adjust your toolbars. Position your mouse cursor over the dotted lines to the very left of the toolbar you wish to move. You'll see a horizontal line with arrows on each side. Hold down the left mouse button and drag the toolbar to the desired location. Once you've placed your toolbar, release the left mouse button for placement.

Another way to save space is to adjust the size of your icons. You can choose Large or Small icons.




## Icons

Icons are a one click method to accessing a specific area of a patient's transplant record. Selecting the drop-down arrow beside an icon allows you to quickly add or access other areas of the application.

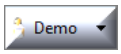
**Find Patient**

Selecting this Icon opens the Patient Search window.

The drop-down arrow allows you to select the New Patient and New Patient Referral form.

**Review**

Selecting this Icon opens the Patient Review window. If you are within another area of the patient's record and need to return to the main review screen, select this icon.

**Demographics** 

Selecting this Icon opens the Patient Demographics window. This window groups information into a logical order for ease of data entry and retrieval.

**Death Info**

Selecting the drop-down arrow next to the Demo Icon opens the Death Information for the selected patient.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**Insurance** Selecting this Icon opens the Insurance coverage for the selected patient. It displays the patient's current insurance and also historical insurance providers.

**Insurance Notes** Selecting the drop-down arrow next to the Ins Icon allows you to access Insurance Notes for the selected patient.

**Labs** Selecting this Icon opens the Labs for the selected patient. This icon opens the appropriate flow sheet based upon the patient's Treatment Phase.

**Add Lab/Misc Labs/Flowsheets** Selecting the drop-down arrow next to the Lab Icon allows you to enter a lab, access Miscellaneous Labs and view certain flowsheets.

**Medications** Selecting this Icon opens the Medications window for the selected patient.

Selecting the drop-down arrow next to the Medications Icon allows you to add a medication to the patient's record.

**Actions** Selecting this Icon opens the Actions window for the selected patient.

Selecting the drop-down arrow next to the Actions Icon allows you to add an action to the patient's record.

**Progress Notes** Selecting this Icon opens the Progress Notes window for the selected patient.

Selecting the drop-down arrow next to the Notes Icon allows you to add a progress note to the patient's record.

**General Medical** Selecting this Icon opens the General Medical window for the selected patient which contains information such as Primary Diagnosis, ABO verification, and Patient Status.


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**Diagnosis(Problem List)** Selecting this Icon opens the Problem List or a list of diagnoses for the patient.

Selecting the drop-down arrow next to the Diagnosis Icon allows you to add a diagnosis to the problem list for the selected patient.

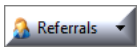
**Text Documents**

Selecting this Icon opens the Text Documents for the selected patient.

Selecting the drop-down arrow next to the Text Documents Icon allows you to add a Text Document to the patient's record.

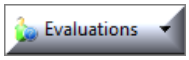
**Providers**

Selecting this Icon opens the Care Providers window for the selected patient.

**Referrals** 

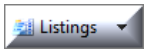
Selecting this Icon opens the Referral window for the selected patient.

Selecting the drop-down arrow next to the Referral Icon allows you to add a Referral to the patient's record.

**Evaluations** 

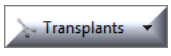
Selecting this Icon opens the Evaluation window for the selected patient.

Selecting the drop-down arrow next to the Evaluations Icon allows you to add an Evaluation to the patient's record.

**Candidate Listing** 

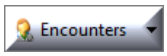
Selecting this Icon opens the Candidate Listing window for the selected patient.

Selecting the drop-down arrow next to the Listings Icon allows you to add a Candidate Listing to the patient's record.

**Transplant** 

Selecting this Icon opens the Transplant window for the selected patient.

Selecting the drop-down arrow next to the Transplants Icon allows you to add a Transplant to the patient's record.

**Encounters** 

Selecting this Icon opens the Encounters window for the selected patient.

Selecting the drop-down arrow next to the Encounters Icon allows you to add an Encounter to the patient's record.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**Potential Donors**

Selecting this Icon opens the Potential Donors window for the selected patient (Recipient).

Selecting the drop-down arrow next to the Potential Donors Icon allows you to add a new Potential Donor to the Recipient's record.


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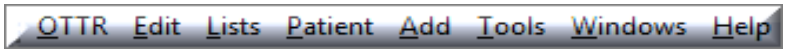
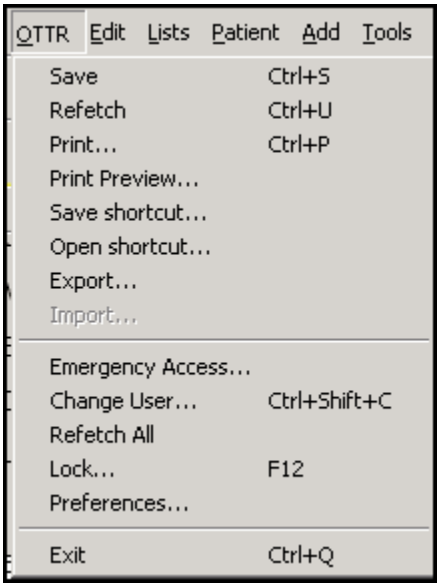
## Master Menus

The OTTR™ Master Menus are displayed directly below the title bar and consist of the following options: OTTR, Edit, Lists, Patient, Add, Tools, Windows and Help.




*Note: Options that are greyed out aren't available in the current window.

1. OTTR Master Menu




**Refetch:** Refreshes the current screen. If new information has been entered and does not display, you can refetch this information from the database to display it. Click Ctrl+U keys to accomplish the same outcome.

**Print:** This option is useful when graphing labs or printing a text document. Click Ctrl+P keys to accomplish the same outcome.

**Print Preview:** Use this to preview an item prior to printing.

**Save Shortcut:** This option is no longer used.

**Open Shortcut:** This option is no longer used.

**Export:** You can export a list to excel by selecting the export option.

**Import:** This menu option is not utilized in the client application. It is utilized within the OTTR™ Admin application.

**Change User:** Allows the current workstation to be utilized by multiple users. If needed, another user may log into the OTTR™ application by selecting the **Change User** menu option.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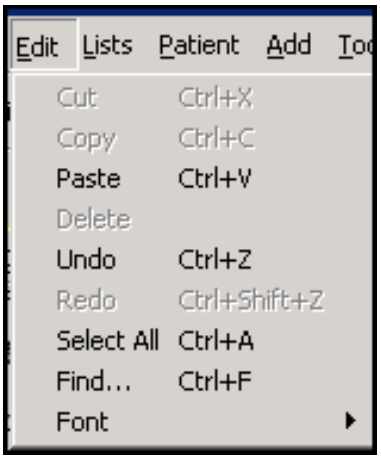
**Refetch All:** When configuration changes have been made within the Admin application and the OTTR™ Administrator wishes to view those changes without having to exit out of their client application they may select the **Refetch All** option. If the changes made do not display then it is recommended that they exit out of the client application and re-enter it to see if the configuration changes have occurred as desired.

**Lock:** It's important that patient data not be displayed unless a clinician is actively working within the record. To lock the system prior to leaving the workstation, click on the **Lock** menu option or hit the **F12** key.

**Preferences:** To change your OTTR™ password or define personnel preferences, click on the preferences menu option. If permission is allowed, you can define how the system functions based upon the options configured.

**Exit:** This is the recommended way to exit out of the OTTR™ client application at the end of day.

## 2. Edit Master Menu




If you're in a window that allows free text such as **Text Documents** or **Progress Notes,** these menu options will become active. OTTR™ does allow users to copy information from another system or document and paste it into a free text field.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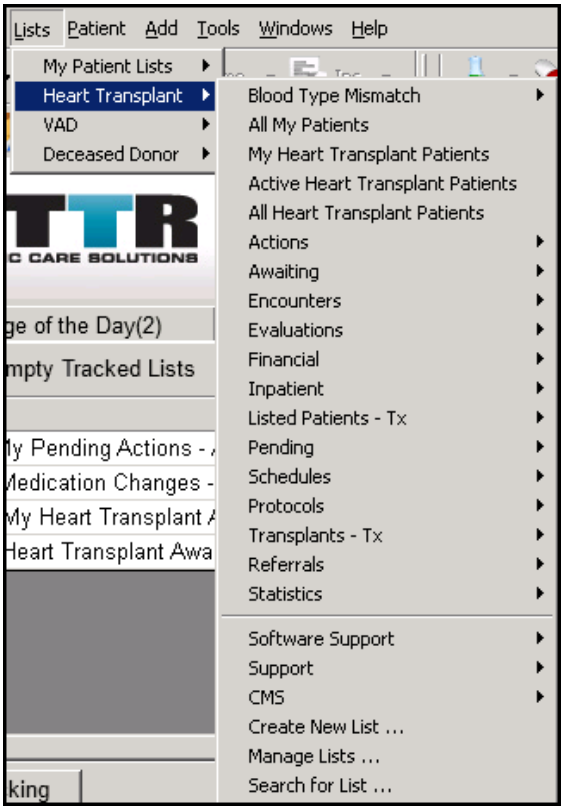
## 3. List Master Menu




To access lists designed to assist with your daily workflow, utilize the **Lists** master menu.

Lists are grouped based upon the process a patient is within (Referral, Evaluation, Mobilization, Transplants, Encounters) or the type of data being displayed within the list (Actions, Schedules, Financial).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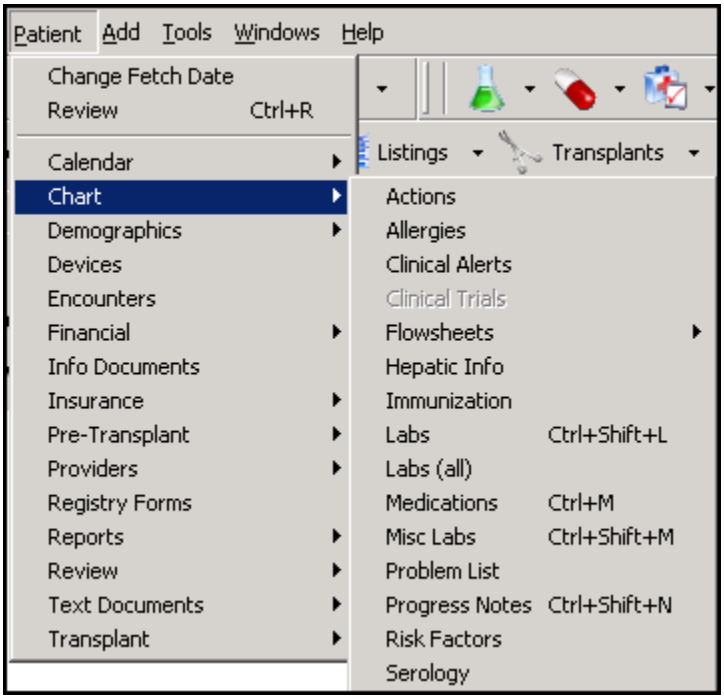
## 4. Patient Master Menu




The **Patient** master menu is the equivalent to a patient's physical medical record. Items found in a standard medical record are also found under the **Patient** master menu.

Click on the **Patient** master menu and select **Chart**. Notice that this area represents the patient's medical record. Report(s) which are specific to one patient are run from Patient\Reports\ {Desired Report}. Flowsheets may be available for quick lab data entry or for graphing purposes.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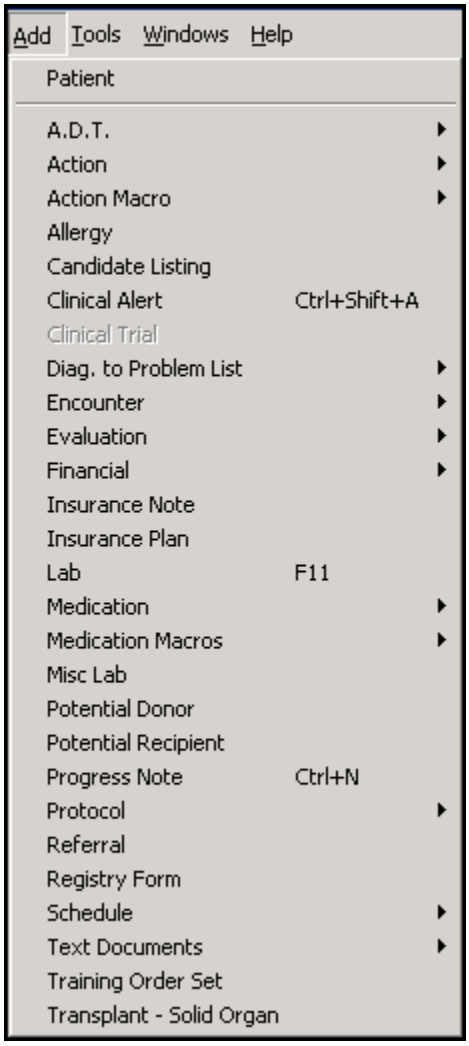
## 5. Add Master Menu




The **Add** master menu displays the most common types of actions, medications, encounters, evaluations, schedules and text documents added to a patient record without having to perform a search. It provides the ability to quickly add the most common items to a patient's record. The OTTR™ Administrator has the ability to configure this area specific to your site's needs.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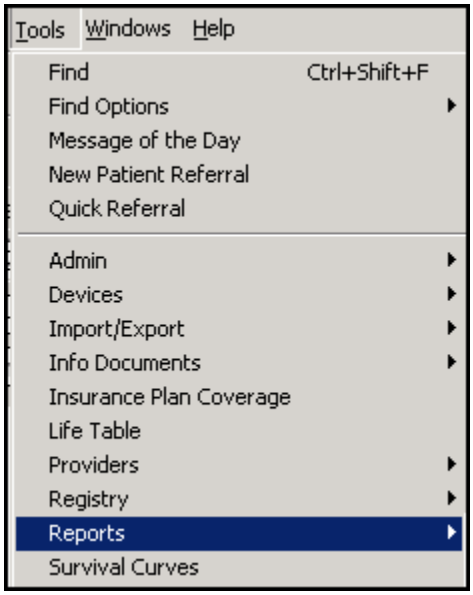
## 6. Tools Master Menu




If a user has the permissions assigned to add providers to the database, they will do so under the **Tools** master menu by clicking on Tools\Providers\Add\Care Providers.

Providers can be Hospitals, Insurance Providers, Pharmacies, Laboratories, and Non Facility Care Providers.

Info Documents which are stored in OTTR™ may be printed for patients as needed.

Reports that apply to all patients within the program are accessed and ran from the Tools\Reports menu option. The **Transplant On Call** report is an example of this type of report.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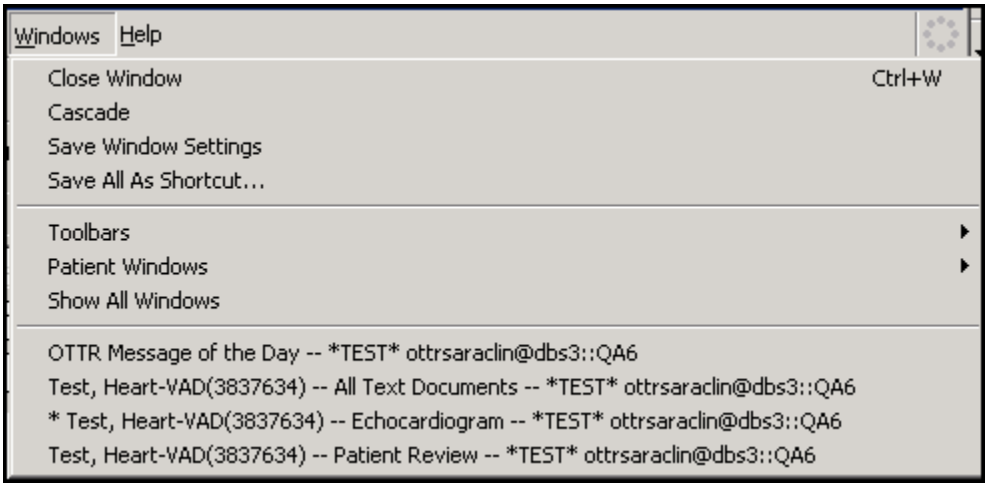
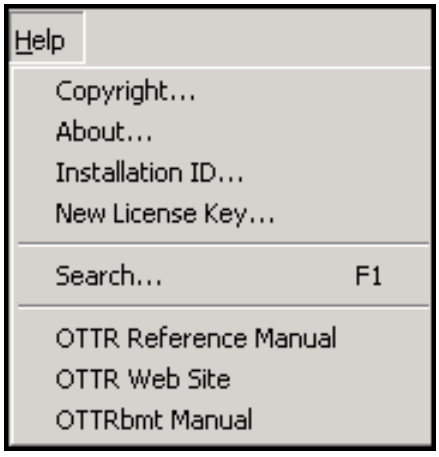
## 7. Windows Master Menu




If you're working in multiple records or have multiple windows open, utilize the **Windows** master menu option to re-enter a patient's record from where it was previously left. You also have access to the various toolbar options from the **Windows** master menu to activate or de-activate toolbars as needed.

## 8. Help Master Menu




To view an electronic copy of the **OTTR™ End User Manual**, click on **OTTR Reference Manual**. For support purposes, if asked what version of OTTR™ you are running click on the **About** menu option to display your version number.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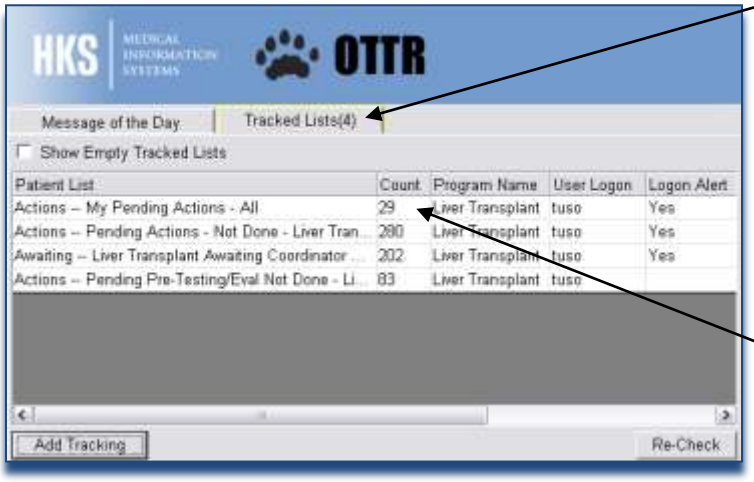
# Tracked Lists



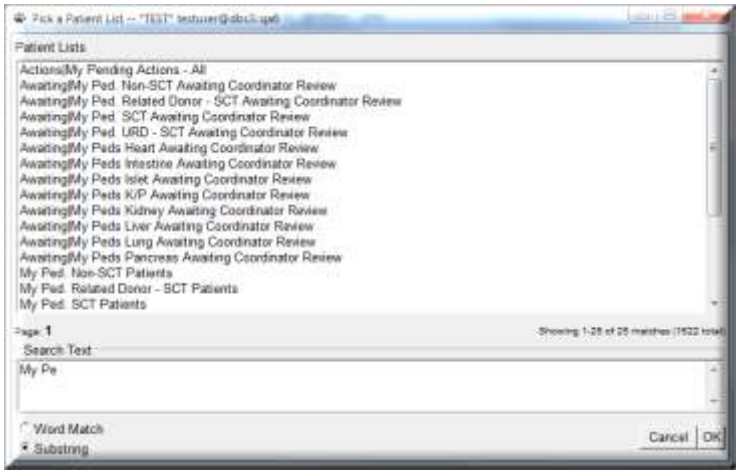

The number next to Tracked Lists details the number of tracked lists that currently have active items.

The Count column details the number of actions on that particular list.

Tracked lists are assigned based upon your role or they may be self-assigned if you have proper permission. The **Message of the Day** window, or the first window you see after you're logged in, displays your assigned tracked lists. This allows quick access to workflow lists to manage your daily tasks. Check the box in front of **Show Empty Tracked Lists** to display of your tracked lists with a 0 count. The **Re-Check** button at the bottom will re-check the system for new items and update the count column when selected.

## Add Tracking

To assign a workflow list to your Tracked Lists, click the Add Tracking button in the bottom left of the Message of the Day window. A Pick a Patient List window opens displaying all lists which the OTTR™ administrator has marked available for tracking. Select the desired workflow list you want to assign and click the OK button.


Patient Lists
Actions\My Pending Actions - All
Awaiting\My Ped. Non-SCT Awaiting Coordinator Review
Awaiting\My Ped. Related Donor - SCT Awaiting Coordinator Review
Awaiting\My Ped. SCT Awaiting Coordinator Review
Awaiting\My Ped. URD - SCT Awaiting Coordinator Review
Awaiting\My Peds Heart Awaiting Coordinator Review
Awaiting\My Peds Intestine Awaiting Coordinator Review
Awaiting\My Peds Islet Awaiting Coordinator Review
Awaiting\My Peds K/P Awaiting Coordinator Review
Awaiting\My Peds Kidney Awaiting Coordinator Review
Awaiting\My Peds Liver Awaiting Coordinator Review
Awaiting\My Peds Lung Awaiting Coordinator Review
Awaiting\My Peds Pancreas Awaiting Coordinator Review
My Ped. Non-SCT Patients
My Ped. Related Donor - SCT Patients
My Ped. SCT Patients
Search Text
My Pe
Word Match
Substring
Cancel
OK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Next, select how you want the list to function:

The **List**, **Program**, **Role** and **User fields** will pre-populate for you and shouldn't be modified.

**Notify when NOT empty –** Placing a check in the box will display your tracked list when it is populated.

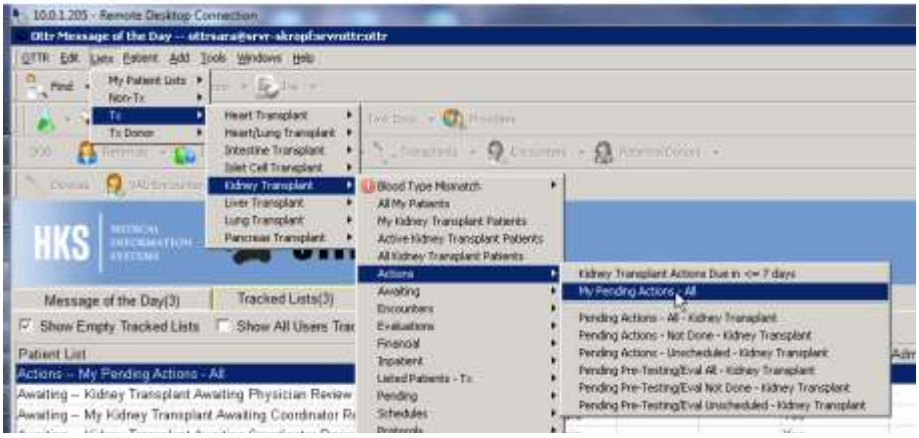
**Alert at logon –** Selecting will cause a message to pop up upon login, notifying you how many counts are on each list.

**Check Every -** Choose how often you want the system to check for new items in minutes or hours. The system will automatically display the list status at the desired time limit entered.

**Tip**: When you login, the system will automatically check for new items.

An alternative way to **Add Tracking** is through the **Master Menu**. From the **Master Menu** select:

**Lists | *specific* Program | category of desired list | *specific* List**


Message of the Day(3)
Tracked Lists(3)
Show Empty Tracked Lists
Patient List
Actions -- My Pending Actions - All
My Pending Actions - All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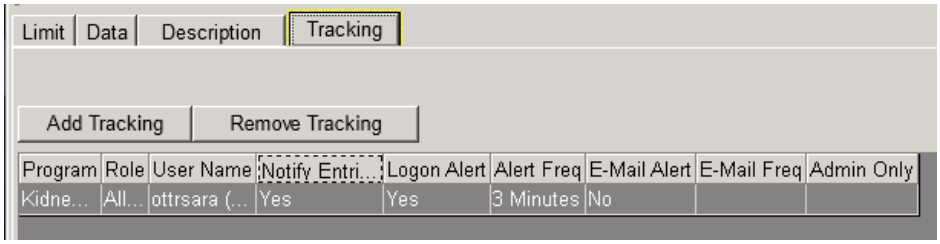
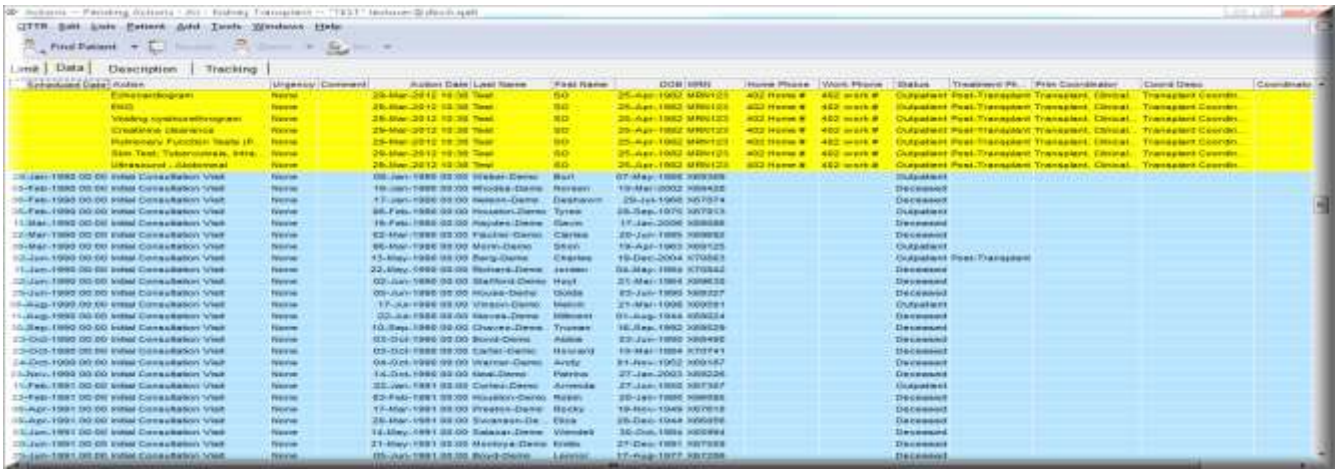



Select the **Tracking** tab and click **Add Tracking** to complete the list set up and add to your tracked lists.
To remove a list from tracked lists, highlight the list and click **Remove Tracking**.

## List Functionality

This section explains how lists may be displayed, sorted, and limited along with an overview of each list tab. Lists consist of columns arranged in a standard order each time the list is opened. You can arrange the columns in a different order to better suit your needs. When you close the list, the columns will return to the standard format. Upon arranging a list to meet your needs, you can minimize it rather than closing it as you continue working in OTTR™.

When a row is highlighted in a list, it represents a patient's record, and all icons located at the top of the window become available for the highlighted patient record. If you double click on a row in the list, it will open certain windows such as the encounter, action, evaluation, transplant record, or to the Patient Review Screen depending on the type of list.



If you want to move a column, select the column header and hold down the left mouse button while dragging the column either left or right of its current position. A green arrow will display to show you where the column will be placed.

To expand a column, position the cursor over the column headers dividing edge. The cursor will change into a double arrow. Hold down the left mouse button while expanding the list column to the desired size.

To sort a list by a specific column, single click on the column header. The list will re-arrange either by date, number, status, or alphabetically A to Z or Z to A; depending upon the column header selected.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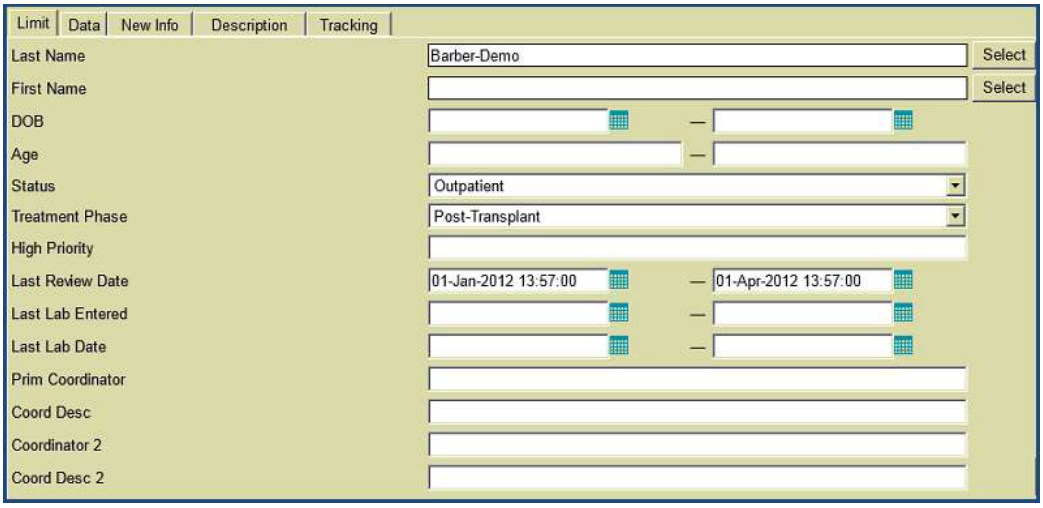
All lists will have a Limit Tab, Data Tab and Description Tab. The New Info and Tracking tab will only show up if it has been activated by your OTTR™ Administrator.

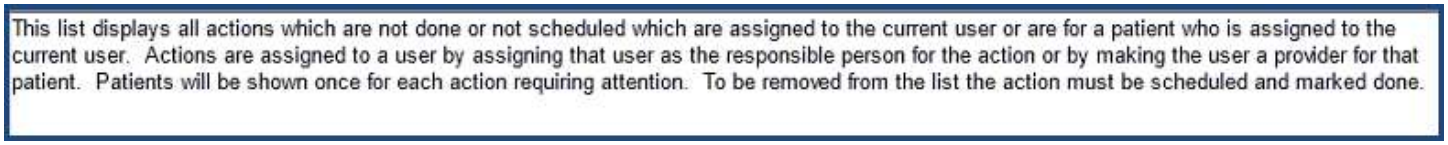
**Limit Tab:** Use the **Limit** tab to search using parameters that will shorten your list such as date or type of action. Each list will have different limit options. Use the **Select** buttons to search and limit by name if applicable, enter dates using the green calendar options, or type in the to and from dates. Drop down boxes and free text areas are also utilized to customize your search. Once you've entered your limiting data, click the **Data** tab to see your results with the limits in place. You can manually clear the limits you've set in the Limit tab or they will default back to no limits when you log out and log back in.




**Data Tab:** The Data tab displays all records which meet a list's description requirement. Information may be sorted by clicking on a column header. Columns may be arranged in a different order by clicking and dragging. Upon exiting the list the columns will revert back to their original order.

**New Info Tab:** Patients who have had new information entered into their record will display within this tabs view. The transplant coordinator will select a record within this tab to review the newly entered data prior to marking the record as having been reviewed.

**Description Tab:** Each list in OTTR™ has a description which explains the purpose of the list, how it's populated, and explains the requirements to remove a patient from the list if it has been designed for workflow purposes.


This list displays all actions which are not done or not scheduled which are assigned to the current user or are for a patient who is assigned to the current user. Actions are assigned to a user by assigning that user as the responsible person for the action or by making the user a provider for that patient. Patients will be shown once for each action requiring attention. To be removed from the list the action must be scheduled and marked done.

**Tracking Tab:** The Tracking Tab allows you to activate the list for tracking. It also places the list on your Tracked List tab in the Message of the Day window.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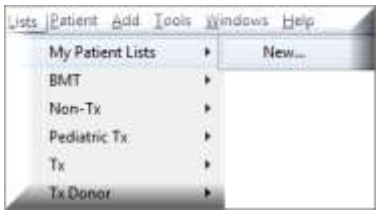
## List Alerts

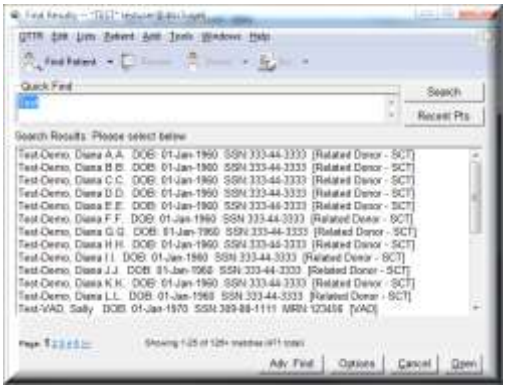
Alerts assigned to critical workflow lists serve as a visual clue to you that a patient record requires immediate attention. Alerts can be added to a list by your OTTR™ Administrator. If a patient record has been flagged, the Alert window will display each time a patient's record is accessed.

## My Patient List

You now have the ability to create your own lists in OTTR™ so that you can track certain groups of patients. Lists could be designed to display patients which are on a clinical trial or for other tracking and research purposes. To build a New List, select the Lists Master Menu option and then highlight the My Patient Lists option. Once that has been selected, move your cursor to the New… option. Enter the title for your list in the Description field.



Next, select the Add Patient button. The Find Patient/Quick Find window will appear. Search for the patient you wish to add to your list. Add additional patients by selecting **Add Patient**. To remove a patient from the list, highlight the row and select **Remove Patient**. To review lab results for the patients select the New Info tab.

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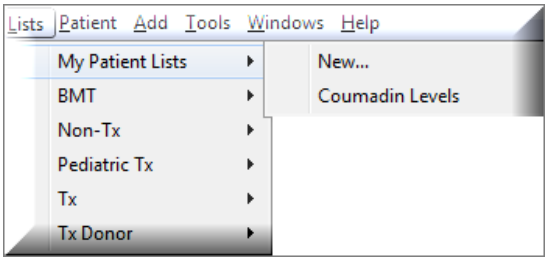
Now that you have created a list by naming it and adding patients to it, the list becomes available under the Lists\My Patient Lists menu option. You can create multiple lists which combine patients for your own specific needs.




## Deleting a My Patient List

To delete a list you must first remove all of the patients within the list. Highlight each patient and select **Remove Patient**. Once all of the patients have been removed, the **Delete List** option becomes active. Select **Delete List** to remove the list from your My Patient Lists menu option.

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# List Descriptions

This section reviews many of the standard lists in the OTTR™ application that we feel would be helpful to familiarize yourself with.

**Active Patients:** This list displays only Active patients. Each patient should display only once. To populate the list the patient's status is active. To be removed from the list, the patient must have been marked; Expired, Lost to Follow-up, or Inactive.

**All Patients:** This list shows all patients within the program. It will include patients who are living; expired; active; and inactive. Each patient should only occur once on this list. To populate the list the patient is entered into OTTR™ and assigned a program. Patients will not be removed from this list.

**All My Patients:** This list displays all patients within the program who are assigned to the current user. To populate the list the current user must be assigned as a care provider for the patient. To be removed from the list, the care provider must be removed from the care providers list within the patient's record.

**Actions – Actions Due in <=7 days:** This list displays actions that are scheduled to occur within the next 7 days. Patients will be shown once for each action. To populate the list a scheduled action must be occurring within the next 7 days. To be removed from the list an action must have a schedule date which has passed today's date.

**Actions – My Pending Actions All:** This list shows actions that have not been scheduled or marked done and are assigned to the current user. These actions will include those for patients who are assigned to the current user or actions

that have been assigned to the current user as a responsible person. To have an action removed from the list the action needs to have a scheduled date and a done date.

**Actions - Pending Actions - All:** This list displays all actions that are unscheduled and have not been marked done. To populate the list, a patient must have an action which requires scheduling and for it to be marked done. To be removed from the list, the action will need to be scheduled and marked done.

**Actions - Pending Actions – Not Done:** This list displays all actions that are not marked done. To populate the list, a patient must have an action that requires it be marked done. To be removed from the list, the action must be marked done.

**Actions – Pending Actions – Unscheduled:** This list displays all actions which are not yet scheduled. To populate the list, a patient must have an action which requires scheduling. To be removed from the list, the action must have a scheduled date.

**Awaiting Coordinator Review:** This list displays patients who have received new documentation within their OTTR™ record. All information must be reviewed prior to selecting the Marked Reviewed button. Patients may have multiple labs or documents which need reviewed. Select the New Info tab to review the new labs and documents. To populate the list, a patient must have new information such as labs, radiology records, pathology records, etc and will consist of interfaced or manually entered information. To be removed from the list, all new data must be Marked Reviewed.

**Awaiting Physician Review:** This list displays patients that a coordinator has marked as **Send for Physician Review**. The physician must review the patient's new data and the coordinators documented concern. To populate the list, a coordinator marks new data as **Send for Physician Review** within the **Awaiting Coordinator Review List**. To be removed from the list, all new data must be Marked Reviewed.


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**Holding for Lab Completion:** Patients are placed on this list by the transplant coordinator while working within the **Awaiting Coordinator Review List**. If lab results have come in for a patient and they do not have all of the results needed prior to marking the patient reviewed, select the Hold button which places the patient onto the list. When any new information has been added to this patient's record they will be removed from this list and back to the **Awaiting Coordinator Review List**.

**My Awaiting Coordinator Review:** This list displays patients who have the coordinator assigned as a care provider. This list is identical to the Awaiting Coordinator Review List. The difference is that the patients within have been assigned to the current user as a care provider. To populate the list, a patient must have received new information. To be removed from the list, all new data must be Marked Reviewed.

**Encounters – Chronological Encounters:** This list displays all encounters for patients. A patient may be displayed multiple times, once for each encounter. Encounters are not removed from the list.

**Encounters - Chronological Encounters for Past 12 Months:** This list displays all encounters that a patient has had within the past twelve months. A patient may be displayed multiple times, once for each encounter.

**Encounters – Unsigned Encounters:** This list displays encounters which have not yet been signed off. A patient may be displayed multiple times, once for each encounter

**Chronological Evaluations:** This list displays all evaluations in chronological order.

**Open Evaluations:** The list displays all active patients which have an open evaluation record. To remove a patient from this list, an End Date and End Reason must be entered into the End tab of the evaluation record.

**Financial – Actions Needing Pre-Auth with Patient, Plan and Type:** This list displays actions that require financial authorization. Actions that have a financial coverage rule will also display on this list.

**Financial - Awaiting Financial Coordinator Review:** This list displays patients who require financial review. A patient is added to this list by adding a **Send for Insurance Authorization** action. The patient is removed from the list when the action has been marked done.

**Financial – Pending Benefits Verification:** This list displays all patients who are in the Referral Treatment Phase and do not have an entry within the Effective Starting date field, Until date field and Verified On date field under the Verification tab of the patient's **Insurance Plan** window. The financial coordinator will verify the patient's insurance plan benefits. To remove a patient's record from this list you must enter the Effective date, Until date and Verified On date and also select **Mark Reviewed** in the Verification tab on **Insurance Plan** window.

**Financial – Plan with Patient Count:** This list displays the total number of patients which have a specific Insurance Company, Plan and Group.

**Financial – Active Patients with Insurance and With No Coverage Rules:** This list displays the insurance providers who do not have any financial coverage rules set.

**Financial – Billable Actions:** This list displays all patients who have had a Billable action ordered. If there is a need to split the Hospital Billing from the Clinic Billing, this list may be utilized to do so. Additional selection choices may be added to the billing status such as Clinic Billing or Hospital billing.


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**Financial – Pending MAP Re-verification:** This list displays patients that have Unknown or Yes selected next to the Enrolled In Medication Access Program. This information is located in the Prescription Benefits tab of the patient's Insurance Plan window. To remove a patient from this list, select the No option next to the Enrolled In Medication Access Program. You can also enter a date within the Date Enrolled field and Until date field located under the Prescription Benefits tab of the patient's Insurance Plan window.

**Financial – Pending Pre-certification:** This list displays patients who are in the Evaluation Treatment Phase and have either Unknown or Yes selected within the Authorization Required for Evaluation field. These fields are located under the Authorization Numbers tab of the Insurance Plan window. To remove a patient's record from this list, enter the Evaluation Pre-certification Number under the Authorization Numbers tab of the patient's Insurance Plan window.

**Financial – Pending Prior Approval Re-verification:** This list displays patients who are Listed Candidates and are within 10 days of the Until date within the Authorization Numbers tab of the patient's Insurance Plan window. To remove a patient's record from this list, the user must call the patient's insurance case manager to re-verify insurance coverage. Enter a new Until date, Verified On date and a Re-verify On date under the Authorization Numbers tab of the patient's Insurance Plan window.

**Financial – Pending Transplant Plan Approval:** This list displays patients who have completed a financial consultation and have had the formal document given to them for their approval/signature. An entry date will be entered within the Transplant Plan Sent field and Financial Consultation Completed field. However, no entry within the Transplant Plan Approval field will be entered. This is located under the Authorization Numbers tab of the patient's Insurance Plan window. To remove a patient's record from this list the financial coordinator will enter the date which they received the signed copy from the patient within the Transplant Plan Approved field under the Authorization Numbers tab of the patient's Insurance Plan window.

**Financial – Pending Transplant Plan Sent:** This list displays all patients who have a date entered within the Financial Consultation Completed field. However, a date has not been entered within the Transplant Plan Sent field under the Authorization Numbers tab. This is located under the Authorization Numbers tab of the patient's Insurance Plan window. To remove a patient from this list, the financial coordinator must create this written documentation to be sent to the patient. Upon sending to the patient, the financial coordinator will enter the Transplant Plan Sent date under the Authorization Numbers tab of the patient's Insurance Plan window.

**Financial – Pending Transplant Prior Approval:** This list displays patients who are within the Listed Treatment Phase and have either Unknown or Yes selected next to the Authorization Required for Transplant field under the Authorization Numbers tab of the Insurance Plan window. To remove the patient's record from this list, enter the Transplant Prior Approval Number under the Authorization Numbers tab of the patient's Insurance Plan window.

**Financial – Plan with Patient Count:** This list displays the total number of patients who have a specific Insurance Company, Plan and Group. This list may be helpful when negotiating global rates or agreements with insurance providers.

**TX Census List:** This list displays patients who are currently inpatients. Patients automatically display on this list when OTTR™ receives an Admit event from the A.D.T interface. To be removed from the list OTTR™ receives a Discharge event from the A.D.T. interface.


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**Active Patient Demo Changes:** This list displays patients who have a new demographic item from the ADT interface that must be reviewed prior to posting it to a patient's record. To be removed from the list, the demo changes must be reviewed.

**Admitted Patient (A.D.T.):** This list displays all patients currently admitted to the facility. To be removed from the list, the patient must have a discharge event entered into OTTR™.

**Chronological (A.D.T.):** This list displays all historical Admit, Discharge, and Transfer Events per patient. Patients are not removed from the list.

**Listed Patients:** This list displays patients who are currently listed for transplant. To be added to the list, a candidate listing record must be created within the patient's record. To be removed from the list, the listing end date must be entered into the candidate listing record.

**Average Waiting Times (Current):** This list displays blood type and the average number of days the patient is listed prior to transplant.

**Chronological Listings:** This list displays all Listing records that have been entered in chronological order. To be added to this list, a patient must have a candidate listing record. Patients are not removed from this list.

**Listings and Insurance:** This list displays patients who have an active candidate listing record with their assigned insurance provider's contact information. To be added to the list, a patient must have a listing record. To be removed from the list, the listing end date must be entered.

**Patients with Unverified ABO:** This list displays patients who do not have the ABO marked verified by two individuals within the General Medical window.

**All Pending Patients:** This list displays patients who have a pending evaluation action, non-evaluation action, schedule or new medication. To be removed from the list, the action must be marked done or medication marked as patient notified.

**All Medications Pending Signoff:** This list displays patients who have a medication order that is not signed off. To be removed from the list, a user with sign off permissions must sign off on the medication.

**Medication Changes:** This list displays patients who have had medication changes made but have not been marked notified. To be removed from the list, the Patient Notified check box within the medication inspector window must be checked.

**Medications Ending <=14 days from now:** This list displays patients who have medications due to end within the next 14 days. Patients are removed from the list when the medication end date passes.

**My Medications Pending Signoff:** This list displays patients who the physician is assigned to which require the medication order to be signed off. To be removed from the list, the medication must be signed off.

**Repeat Labs:** This list displays patients who have had a repeat lab action ordered and it has not been scheduled or marked done. To be removed from the list, the action needs to be marked done.


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**Active Protocols:** This list displays patients on an active protocol within a program. To be removed from the list the protocol end date must be entered.

**Chronological Protocols:** This list displays all patients that have been, or are currently active, on a protocol for a particular program in chronological order. Patients are not removed from this list.

**All Protocols:** This list displays all protocols available in the system.

**Active Referrals:** This list displays referrals which have been entered into the system and have not yet been ended. Patients may display on the list more than once if they multiple open referrals. To be removed from the list, a referral End date is required.

**Chronological Referrals:** This list displays all referrals documented in the system in chronological order. Patients may be displayed more than once if the patient has more than one recorded referral. Patients are not removed from this list.

**Counts by Referring Physicians:** This list displays all referrals and distinct patient count of referrals sent to the program by an individual physician.

**Referral Outcomes by Referring Physician:** This list displays the count of number of referrals that have occurred for that physician with that end reason and totals the number of patients in that category. A physician row is added when a new combination of referring physician and referral end reason exists within the database.

**All Active Schedules:** This list displays all patients who have an active schedule. The patient is removed from the list when the schedule is ended.

**Overdue Schedule:** This list displays patients who have been assigned a schedule such as lab or clinic visits and the information (result or encounter) has not yet been entered into OTTR™. To be added to the list, an expected schedule date must pass and no result entered. To be removed from the list the expected schedule date must be reset or the expected results must be entered.

**Schedule Changes:** This list displays patients who have had a schedule added to their record and they have not been notified. To be removed from the list, the Patient Notified option must be selected within the schedule inspector window.

**Upcoming Events:** This list displays the patient's last name, first name, schedule type, frequency, next expected schedule date, last schedule date and the schedule end date.

**Active Transplant Patients:** This list displays active patients with age at time of first and last transplant. To be added to the list a transplant record must be created with a patient's record. To be removed from the list the patient must have a date of death entered.

**Transplant - Chronological:** This list displays all transplants in chronological order. To be added to the list a patient must have a transplant record. Patients are not removed from this list.

**Transplant - Retransplants:** This list displays patients who have received more than 1 transplant. Patients are not removed from this list.


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**Transplant – Transplant Patients in Alphabetical Order:** This list displays all transplanted patients in alphabetical order. To be added to the list, a transplant record must be created within the patient's record.

**Transplant – Transplanted Patients:** This list displays all transplanted patients with blood type.

**Transplant - Chronological Failed Grafts:** This list displays patients within the specified program who have had a failed transplant graft and reason for the failure. A patient is added to the list when a graft failure date is entered in the transplant record. Patients are not removed from the list.

**Transplant – Multi Organ Transplants:** This list displays patients who have received a multi-organ transplant on the same day. Patients are not removed from the list.

**Blood type Mismatch - Discrepancy Between Lab and Patient Medical:** This list displays patients who have an ABO lab result which does not match the ABO entered under the General Medical window. To be removed from the list the ABO lab result and the ABO in General medical must match.

**Blood type Mismatch – Potential Donor (ABO or Rh):** This list displays the recipient's name and blood type and the donor's name and blood type. To be added to the list the blood types will not match. To be removed from the list blood types must match.

**Blood type Mismatch – Transplanted (ABO only):** This list displays patients who have been transplanted. It also includes the non-matching ABO for the recipient and donor.

**CMS – Cadaveric Transplants:** This list displays all transplanted patients that have the transplant type of cadaveric. The patient is added to this list when a user enters a transplant event and selects the transplant type of cadaveric. This list displays data for the past 3 years.

**CMS – Current Listed Patients:** This list displays all patients who have an open candidate listing and do not have a listing status of Status 7. Patients are removed from the list when a listing end date is entered.

**CMS – Living Donors:** This list displays all patients who have been living donors. The patient must be a member of a living donor program. The patient is added to this list by attaching the donor to the recipient transplant record and selecting the transplant type of living related or living unrelated. This list displays data for the past 3 years.

**CMS – Patients Removed from Waitlist:** This list displays patients who have been removed from the active waitlist for any reason. A patient is added to this list when a listing end date and reason is entered and saved in OTTR™. This list displays data for the past 365 days.

**CMS – Patient Removed from Waitlist Other than TX/Death:** This list displays patients who have been removed from the active waitlist. A patient is added to this list when a listing end date and reason is entered and saved in OTTR™. The End Reasons that qualify for this list are; Patient transplanted, Patient transplanted elsewhere or Patient expired. This list displays data for the past 365 days.

**CMS – Patients Transplanted:** This list displays all transplanted patients. This list displays data for the past 3 years.


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**CMS – Evaluated, Not on Waitlist:** This list displays all patients who have a completed evaluation but were not listed for transplant. This list displays data for the past 365 days.


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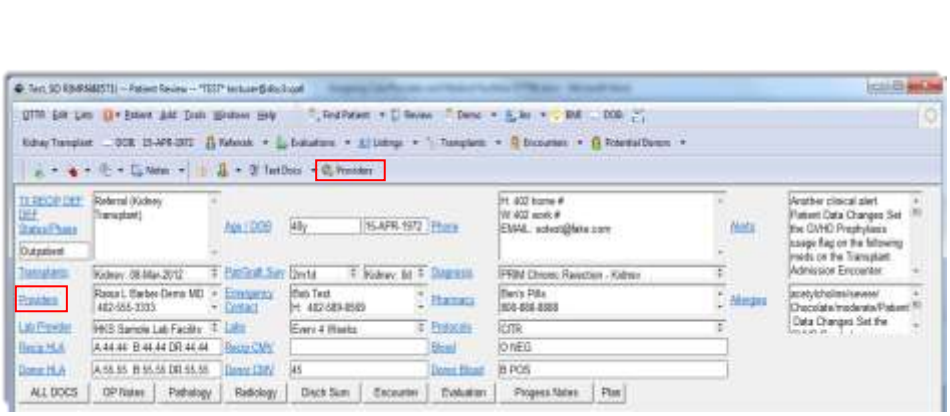
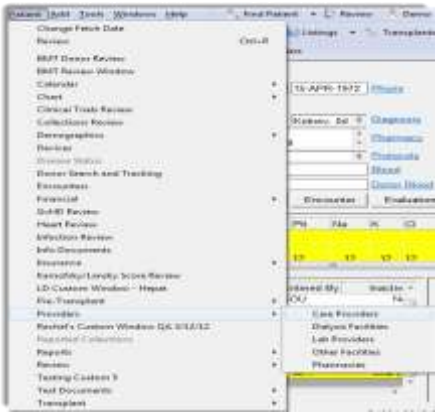
# Assigning Care Providers

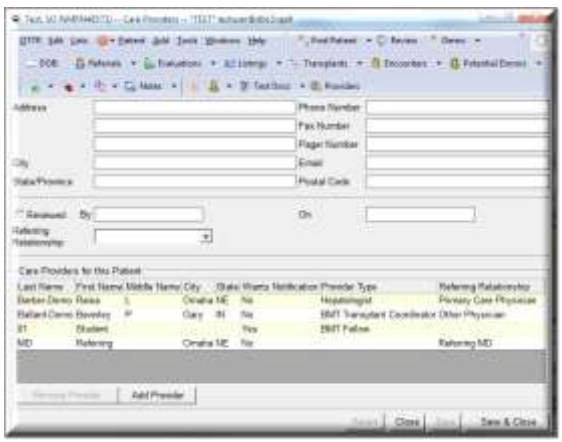
This section explains how to assign Care Providers to a patient's record. Assigning Care Providers allows for population on patient reports, and certain lists are driven based on the assigning of Care Providers such as the My Awaiting Coordinator Review list. There are several ways to access the Provider window:

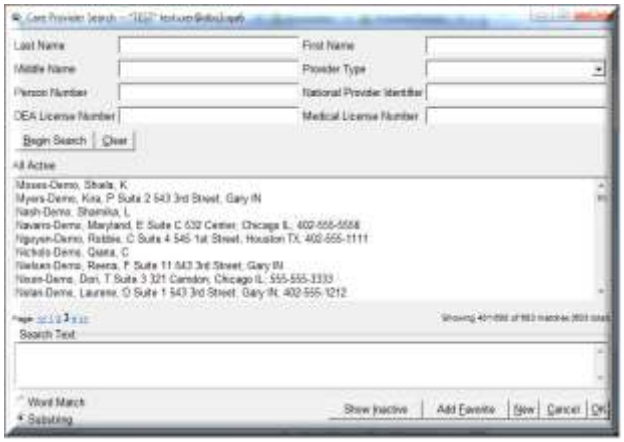
Patient Review Screen - Hyperlink, the Providers Icon or from the Patient Master Menu





Once you've accessed the **Care Providers** window by any of the methods listed above, select the **Add Provider** option. This will open the **Care Provider Search** window.





Type the provider's name into the **Search Text** Field. You can also use any of the search criteria in the top portion of the **Care Provider Search** window. If typing within Search Text, the displayed results will begin to limit by what has been typed until the desired name is displayed. If you are utilizing the search fields, enter the provider's information and select **Begin Search**. Once you've located the provider from either method, you can either double-click on the line item or highlight the line once and select **OK**.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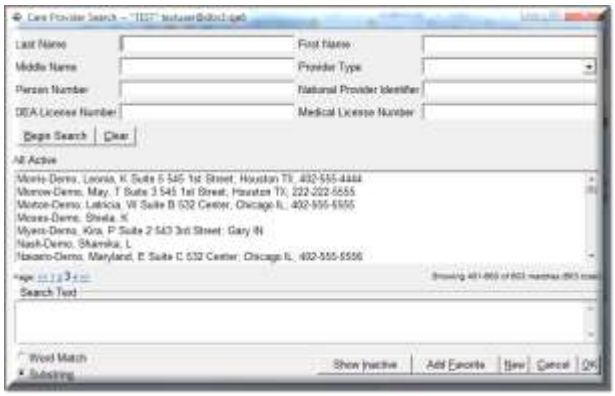
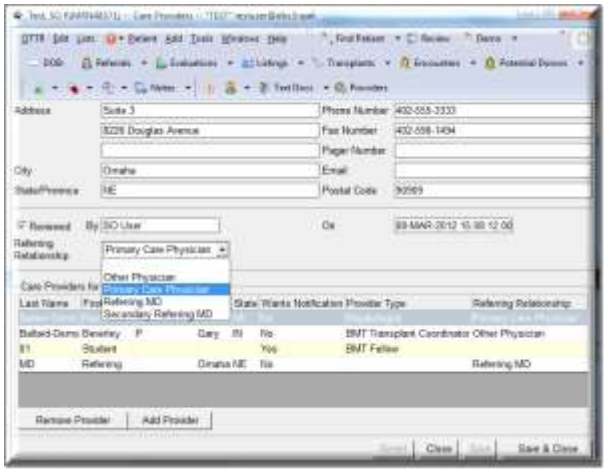
## Creating a New Provider

In the event that your search returns no values, you may need to add the Care Provider to the database. If given the appropriate permissions, add the Care Provider by selecting the **New** button within the **Care Provider Search** window. You will be re-directed to the **Person/Provider Inspector** window. If you are entering a care provider, you will only need to place data in the following tabs; **Name**, **Contact Information**, **Billing Address**, **Identifiers** and **Care Provider Types**. The other tabs are for building user accounts in OTTR™ and are utilized by the OTTR™ Administrator. *If you don't have Admin permissions, these other tabs will be greyed out.



Once you've selected a Care Provider, you'll be re-directed back to the Care Providers window. To view a provider's contact information, highlight the desired provider and the contact information will display in the top portion of this window.



You can also specify the **Referring Relationship** by highlighting the provider and selecting the drop-down option next to the Referring Relationship field. If you need to remove a Care Provider from this list, highlight the desired Care Provider and select the **Remove Provider** option.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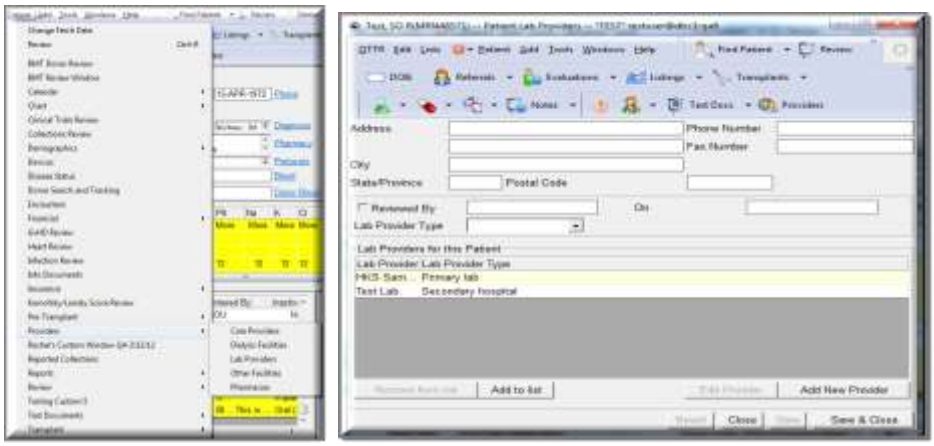
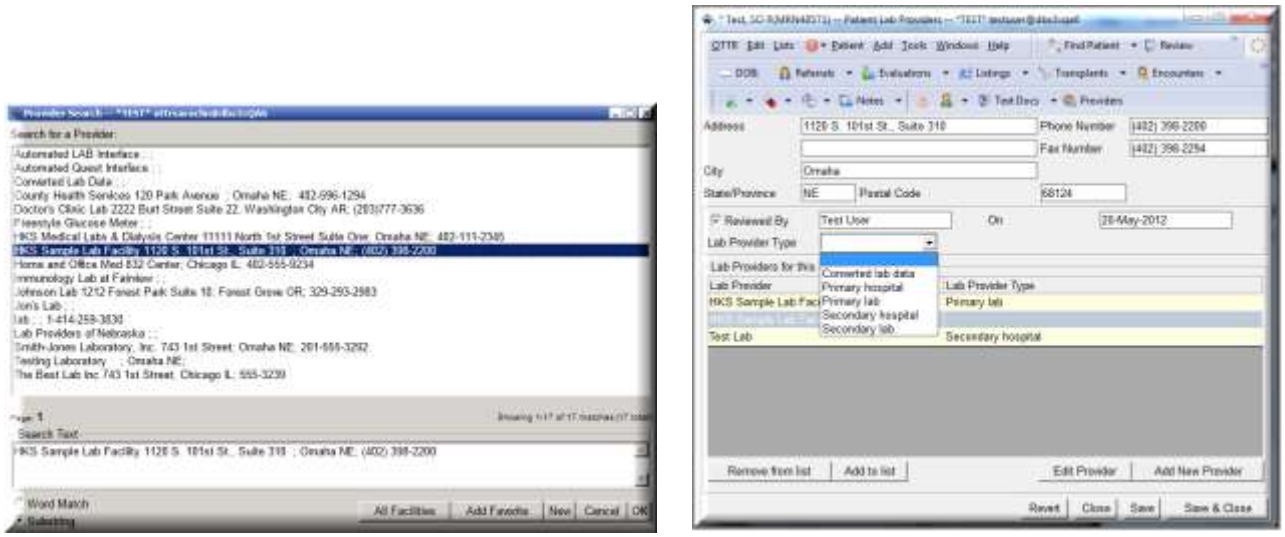
# Assigning a Medical Facility

This section explains how to assign a Medical Facility, such as a laboratory, dialysis center, or pharmacy to a patient's record. It also explains how to add new Medical Facilities to the database. Select the **Patient** Master Menu, highlight the Providers option and select the type of Facility you want to associate to the patient's record. In this example, Lab Providers has been selected.



Select the **Add to list** option to search the database for the desired provider.



Highlight the desired provider from the search list and select the **OK** button to add this provider to the patient record. Once you've selected a provider, you'll be re-directed to the Providers window. If you highlight the line item of the selected provider, you'll see the contact information for that Medical Facility. You can also select the Provider Type by selecting the drop-down option. *If you are adding a dialysis facility to the patient's record, you'll need to mark the facility as primary to populate some of the patient reports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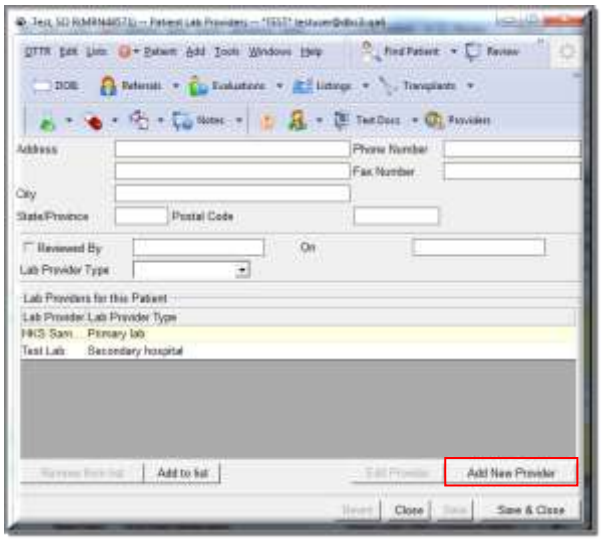
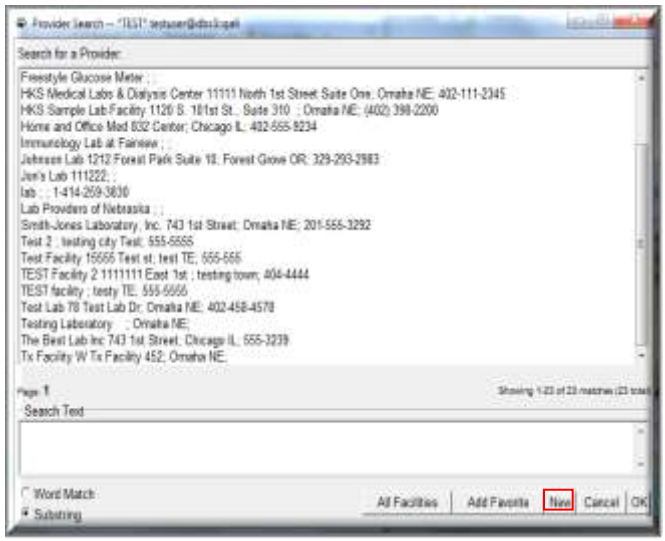
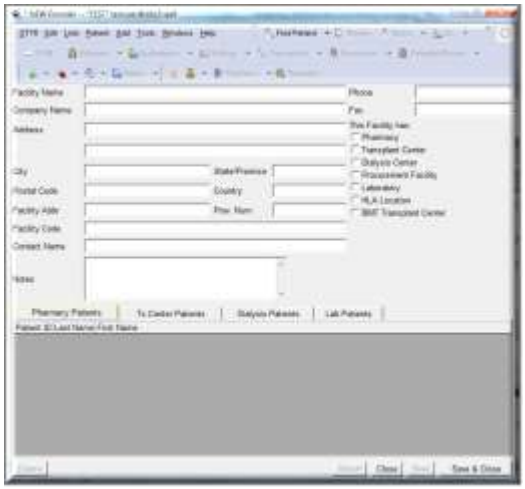
## Adding a New Medical Facility to the Database

If, during the initial search for the provider, it was determined they weren't listed in the database, you can add them if you have the proper permissions assigned. Select the **Add New Provider** option. You can also select the **New** button in the **Provider Search** window.




Once you've selected **Add New Provider** (or the **New** button from the Search window), you'll be re-directed to the New Provider window. Fill out all applicable areas and select the **Save & Close** option. *To designate the Facility Type, select an option under **This Facility has:**

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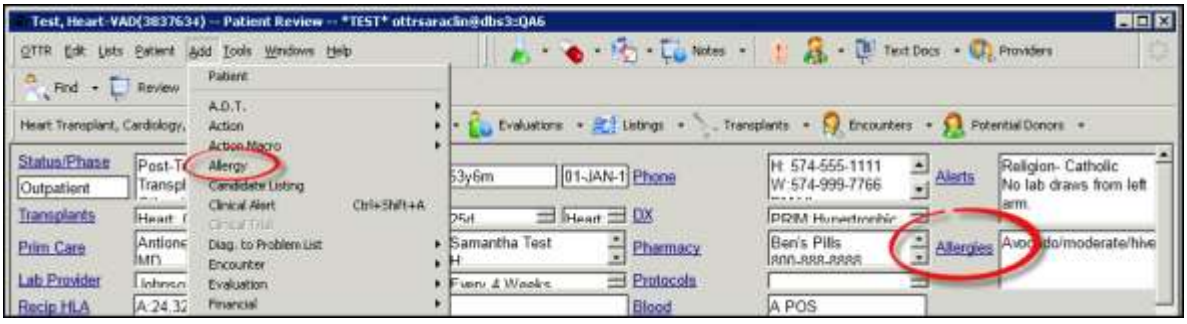
# Alerts and Allergies




## Allergies

Allergies can be viewed on the **Patient Review** window. Allergies can be accessed using the Allergies hyperlink or from the **Add** Master Menu, select **Allergy**.

To modify an existing allergy, double click on the row that you want to modify to open up the Allergy window. To add a new allergy click the **New Allergy** button.

Select the **Type** and **Severity** of allergy using the dropdown boxes.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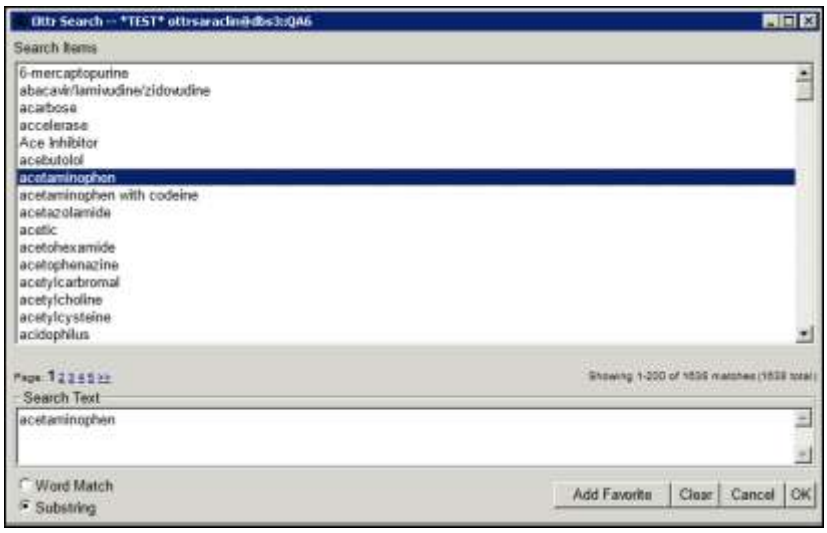


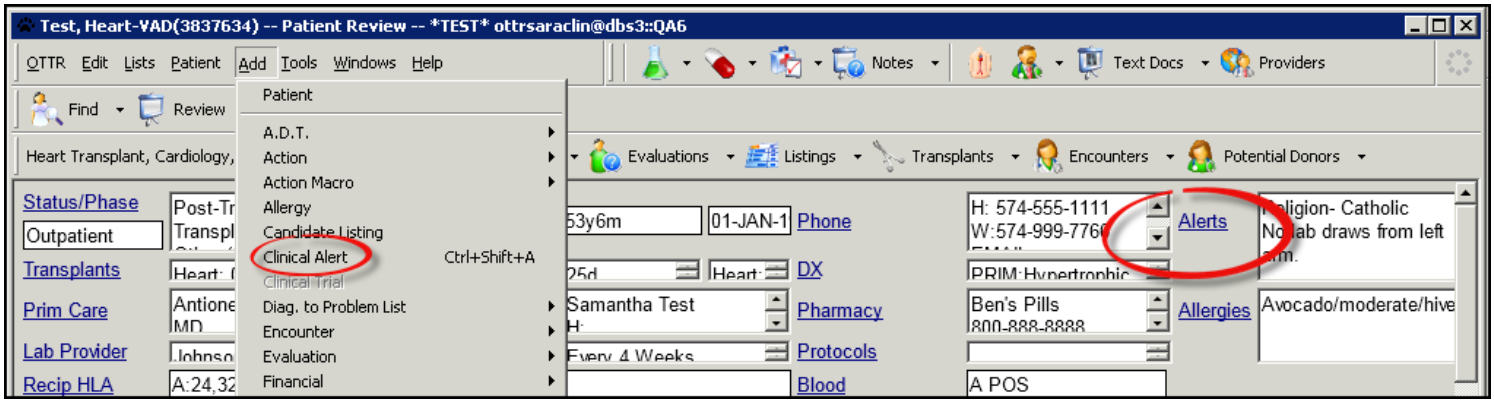

Use the **Set** button next to the **Allergy** field to search for the name of the allergy. Highlight your selection and click **OK** or double click on the selection.

**Note:** You have to first select the Type of allergy prior to entering the name. The search box displayed is determined by the allergy type.

The **Identified On** date will populate with "today's" date. The **Reaction** field can be filled in via free text entry.

Click the **Mark Reviewed By** button to populate the date and name of the logged in user. Some sites may use this feature if a non-clinical person is entering the allergies, a member of the clinical staff will verify and mark reviewed.

**Save & Close** when finished.





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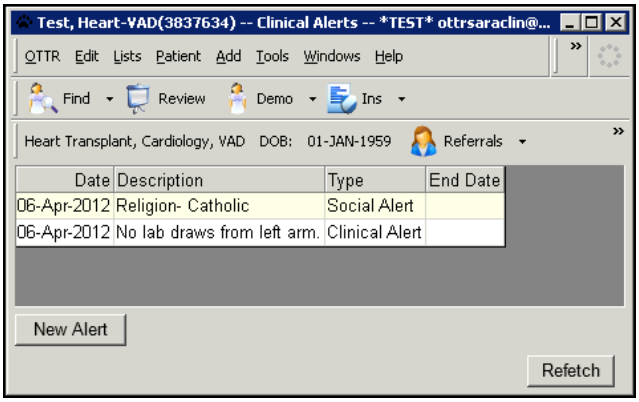
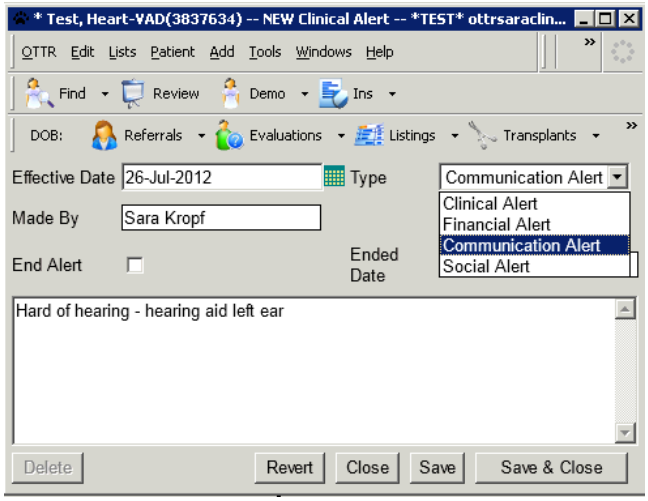
# Alerts

**Alerts** are social, financial, clinical, and communication related and can be viewed on the **Patient Review** window. Alerts can be accessed using the Alerts hyperlink or from the **Add** Master Menu, select **Alert.**


Test, Heart-VAD(3837634) -- Clinical Alerts -- *TEST* ottrsaraclin@...
OTTR Edit Lists Patient Add Tools Windows Help
Find Review Demo Ins
Heart Transplant, Cardiology, VAD DOB: 01-JAN-1959 Referrals
Date Description Type End Date
06-Apr-2012 Religion- Catholic Social Alert
06-Apr-2012 No lab draws from left arm. Clinical Alert
New Alert
Refetch

To modify an existing alert, double click on the row that you want to modify to open up the Alert window. To add a new alert click the **New Alert** button.




The **Effective Date** will populate with "today's" date.

Select the **Type** of alert from the dropdown box.

The **Made By** field will populate with the name of the logged in user.

When the alert is no longer valid or to end the alert, put a check in the **End Alert** and the **Ended Date** will populate with "today's" date.

Free text the specifics of the alert into the free text area.

**Save & Close** when finished.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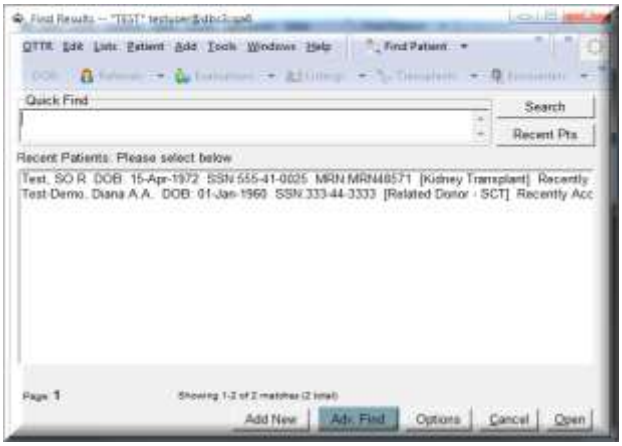
# Find Patient

After logging into the OTTR™ system, the most common step is to locate a patient. This section will explain how to locate a patient using the **Find Patient** option. When searching for a patient, you'll more than likely need more than the basic information to determine if you are selecting the correct patient. The following setup will help you in making that determination.

## Quick Find

Most of the icons associated with your toolbars are grey or inactive until you've opened the patient record. Click the **Find Patient** icon to open the **Quick Find** search window.

This window allows you to search the OTTR™ system for patients, care providers, facilities, or anything with the search criteria you type in the search textbox. To default back to the original Patient Search window, select the **Adv. Find** option at the bottom of the **Quick Find** window.





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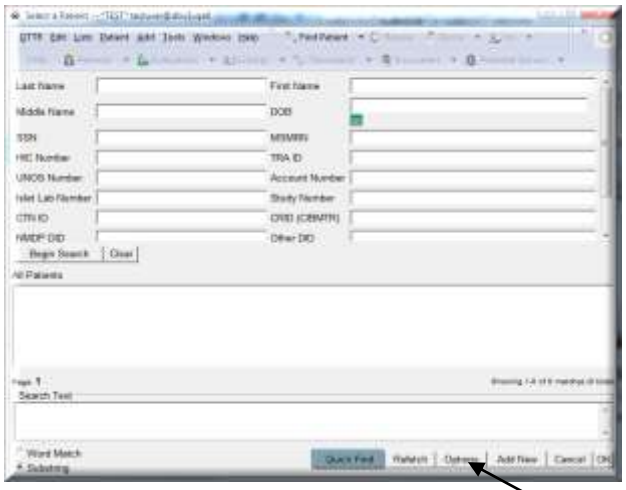
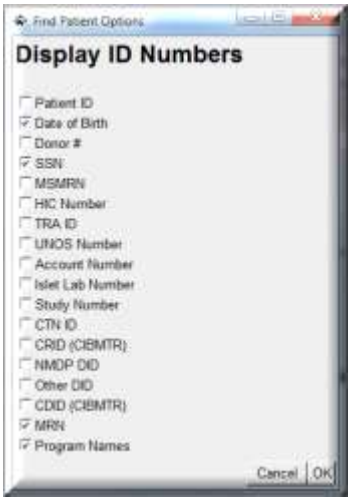
## Advanced Find

This **Advanced Find** window allows you to search the OTTR™ system for patients with the search criteria you type in the search textbox. To default back to the **Quick Find** window, select the **Quick Find** option at the bottom of the **Advanced Find** window.




Use the **Options** button to display other identifiers next to the patient name when your search results are returned. Once selected, these options remain in place for all future patient searches until manually unselected.

**Example:** You have multiple patients with the same first and last name. You also have discovered that this patient has the same date of birth. There are also some identifiers within OTTR™ that are unique such as MRN and SSN. If you selected those in Options, these numbers would display as well to assist you with your search.

Once you you've chosen your options, select **OK** and to return to your **Quick Search** or **Patient Search** window. To search for a patient, you have fields in the top portion of the original **Patient Search** window such as First Name, Last Name, OTTR ID, MRN, etc. You can place data in one of those fields and select **Begin Search**.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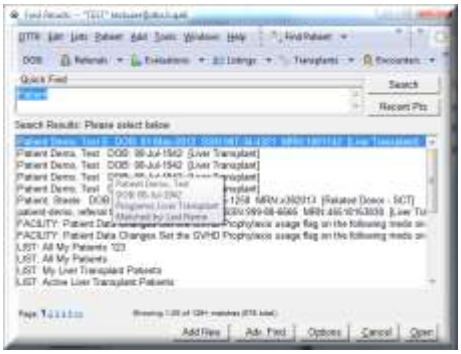
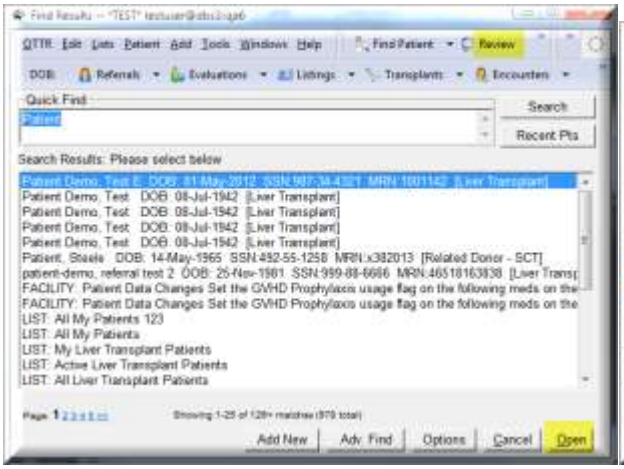
If you're in the **Quick Search** window, start typing the name of your patient in the textbox and then select the **Search** option.



Once you've located the correct patient, you can highlight the line item with your cursor. You now have access to their record from the Master Menus or Toolbar Icons. To open the **Patient Review** window, there are a few options; double-click on the row, highlight the line item and select **OK** at the bottom right of the screen (**Open** in Quick Find), or highlight the line item and select the **Review** icon.



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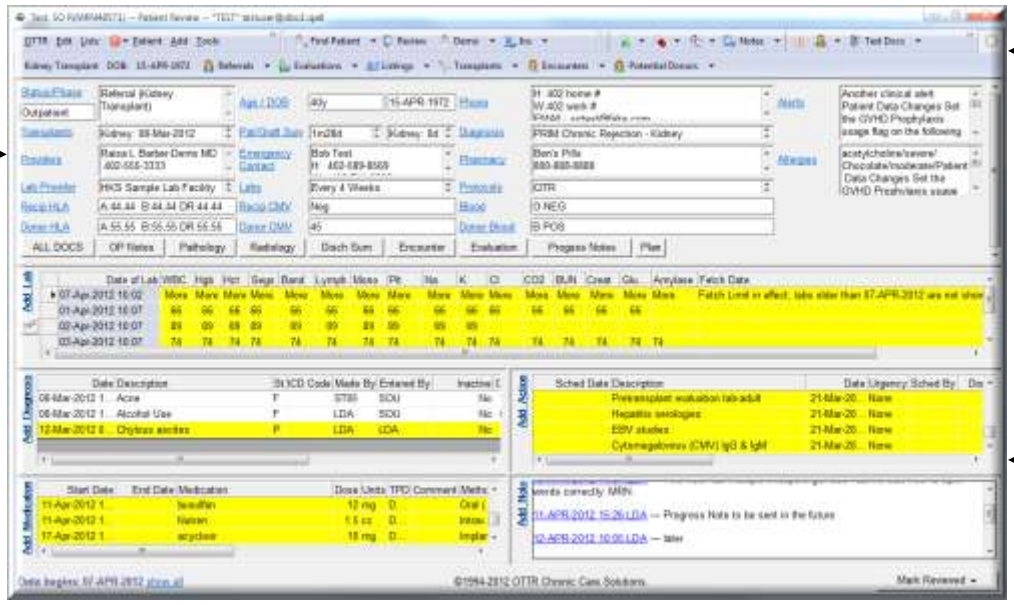
# Patient Review Window

The **Patient Review Window** shows you the most commonly accessed areas of the patient's record, providing an "at a glance" overview.

This section is commonly referred to as the Demo Strip as it holds a lot of the Patient's demographic information.



The top portion of any window opened consists of the Master Menus and Toolbar Icons

The bottom portion of the Review Screen holds Labs, Diagnosis, Actions, Medications and Progress Notes.

The Patient Review Screen consists of several Hyperlinks that are designed to take you to the area of the application that the information is being pulled from.

Example: By selecting the Transplants hyperlink, you will be brought to the Transplants window.

Transplants

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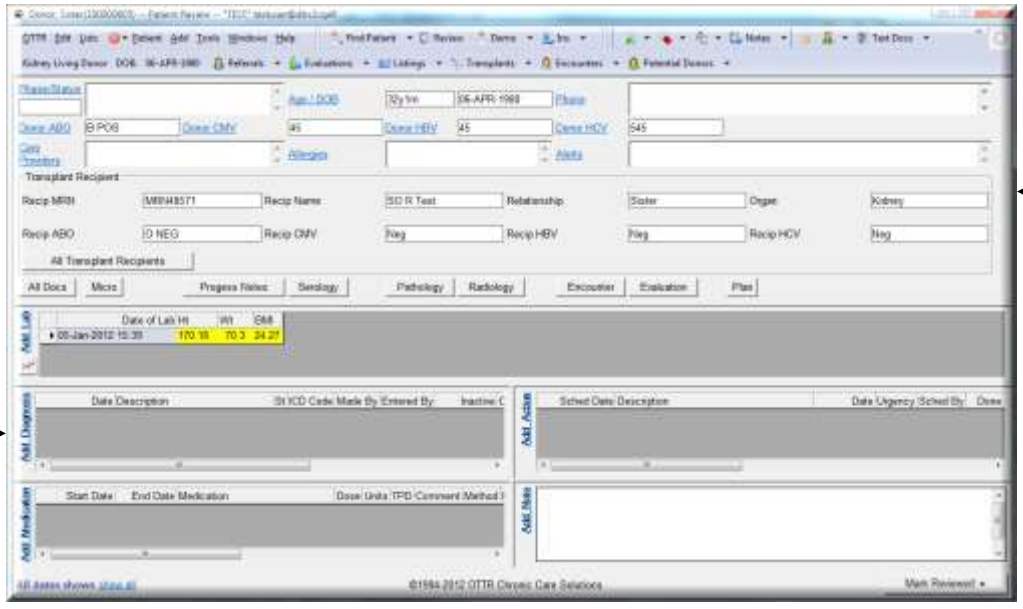
As mentioned earlier, **Icons** are also available from the **Patient Review Screen**. Icons are a one-click method of accessing a specific area of a patient's record. Selecting the icon opens a larger window view of the application. Some of the icons have a drop-down arrow beside them which will allow you to quickly add or access other areas of the application.

Example: By selecting the Demo Icon you will be directed to the Demographics screen for that patient.

Example: By selecting the drop-down arrow and the option next to the Demo Icon, you will be directed to the **Death Info** for that patient.

The Patient Review Screen might be different based on the type of patient you have selected. Donor patients have a separate Review Screen than Recipients. Your OTTR™ Administrator may also configure custom Review Screens based on the needs of your site.



The Donor Demo strip includes Transplant Recipient information

The bottom portion of the Donor Review Screen holds Labs, Diagnosis, Actions, Medications and Progress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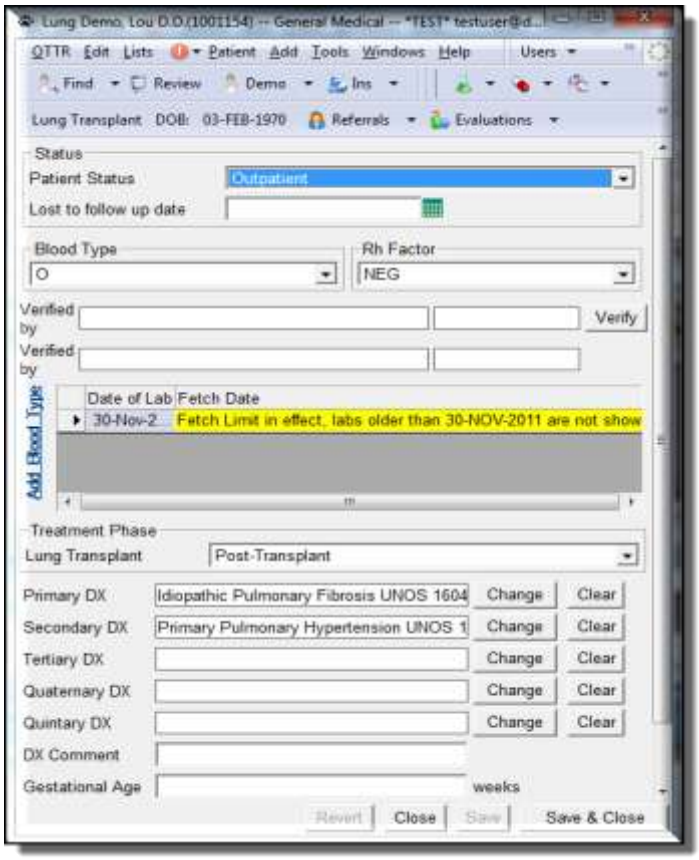
# Problem List - Diagnosis

This section explains the difference between the referring diagnosis and the primary diagnosis while instructing you on how to enter the primary diagnosis, or the diagnosis driving the need for a transplant. During the referral process, the referring provider's diagnosis is entered into the system via the **New Patient Referral** form. This diagnosis remains until it's changed by a clinical team member to reflect what the transplant physician has determined to be the patient's primary diagnosis.

To enter the primary diagnosis, select the **General Medical/Primary Diagnosis** icon .




To add a **Primary DX** or to change the diagnosis from that of the referring provider, select the **Change** button to search for the primary diagnosis desired. The primary diagnosis entered should be what is driving the need for a transplant and reflect the appropriate **UNOS** code. This is especially important for populating the TEIDI forms correctly. The primary diagnosis displays in the **Demo Strip** area of the **Patient Review** window.

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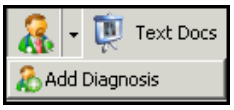
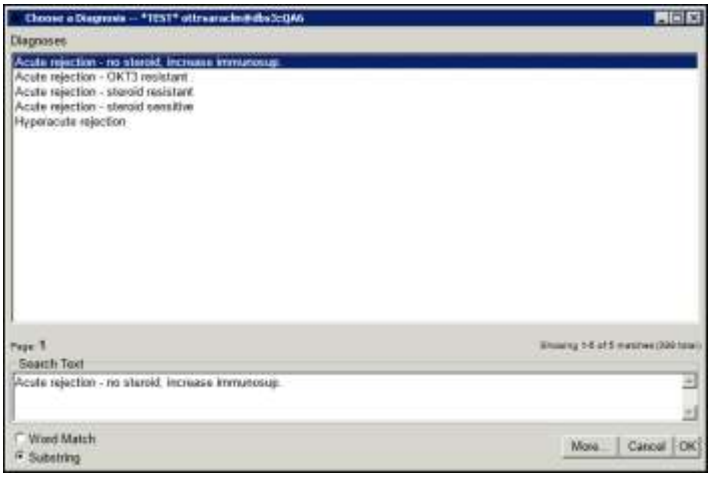
## Problem List

This section explains how to document the on-going problems or diagnoses which a patient will have during the transplant process. These diagnoses are displayed in the following area of the patient's record.

To add a new diagnosis to the patient's Problem List, select the Add Diagnosis hyperlink or the **Add Diagnosis** option from the dropdown next to the **Problem List** icon.




Search for the desired diagnosis in the Search Text box, highlight and click **OK** or just double click to open the **New Diagnosis** window. Note: If you can't find the diagnosis you're looking for, click the **More** button and repeat your search. The **More** button provides access to all options available in the database.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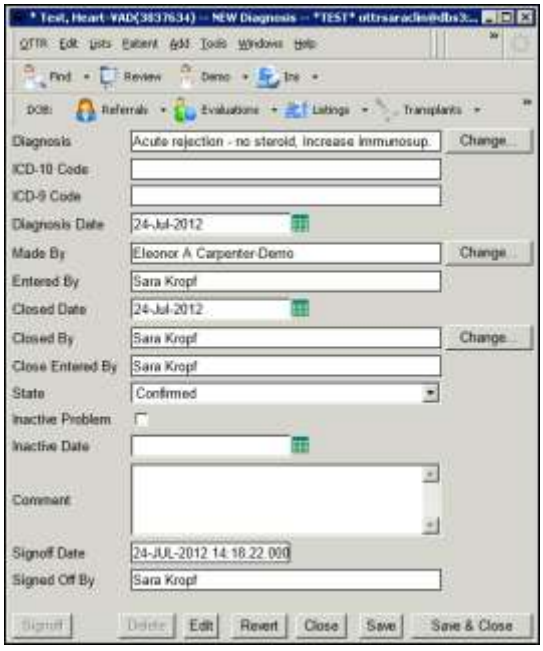
Based on your Roles and Permissions, you might be prompted to select a provider who made the Diagnosis.

Type in the full or partial last name of the provider and click the **Begin Search** button. Highlight your choice and click **OK**, or just double click on the provider. If the provider is one you use often, after you highlight the provider, click **Add Favorite**. You can also narrow down your options at the top, prior to searching, by selecting Favorites, My Programs, and All Users.




**Diagnosis:** Displays the selected diagnosis from the previous window.

**ICD Code**: If entered in the database, it will display here.

**Diagnosis Date:** Defaults to today's date but can be adjusted if the diagnosis was made on an earlier date.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**Made By:** Defaults to the user's name currently logged into OTTR™ if they have permissions to add diagnoses. If not, the user will be required to enter the providers name who made the diagnosis.

**Closed Date:** Enter the closed or ended date if the diagnosis is no longer active.

**Closed By**: Select the **Change** button to select the desired provider responsible for ending the diagnosis.

**Close Entered By:** Enters the user's name that closed this diagnosis in this window.

**State:** Select the drop-down arrow to change the state. For example, **Confirmed** would represent a true diagnosis for the patient, Verified Negative would represent a situation in which a diagnosis was ruled out. A diagnosis will remain yellow until confirmed.

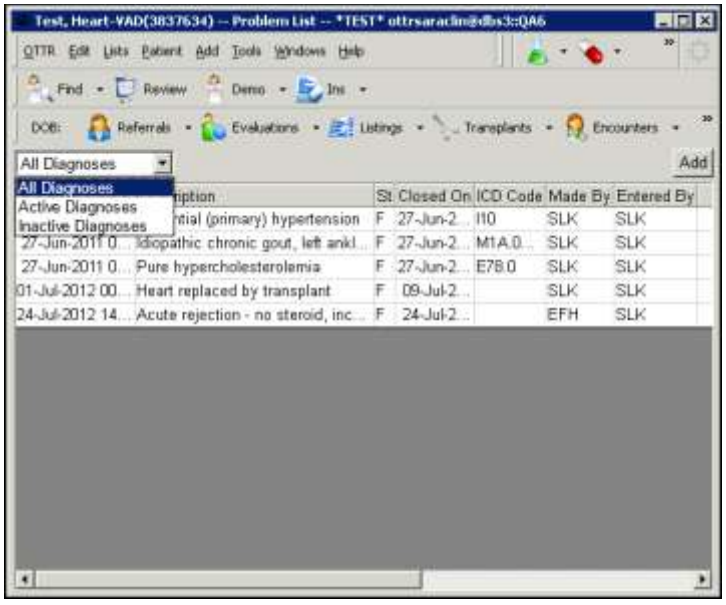
**Inactive Problem:** To mark a problem as inactive, place a check mark with that option box.

**Inactive Date:** Defaults the date which the check mark was placed in the Inactive Problem box.

**Comment:** The clinician may enter a comment about the selected diagnosis if desired. This is a free text field.

**Signoff:** Select Signoff to signoff the diagnosis if applicable to your site.

Once entered, your diagnosis will appear in the patient review window or can be accessed through the problem list icon. In the Problem List window, you can sort by All, Active, or Inactive Diagnoses.


Test, Heart-VAD(3837634) -- Problem List -- *TEST* ottrsaraclin@dbs3:QA6
OTTR Edit Lists Patient Add Tools Windows Help
Find Review Demo Ins
DOB: Referrals Evaluations Listings Transplants Encounters
All Diagnoses
Add
All Diagnoses
Active Diagnoses
Inactive Diagnoses
St Closed On ICD Code Made By Entered By
F 27-Jun-2... I10 SLK SLK
F 27-Jun-2... M1A.0... SLK SLK
27-Jun-2011 0... Pure hypercholesterolemia F 27-Jun-2... E78.0 SLK SLK
01-Jul-2012 00... Heart replaced by transplant F 09-Jul-2... SLK SLK
24-Jul-2012 14... Acute rejection - no steroid, inc... F 24-Jul-2... EFH SLK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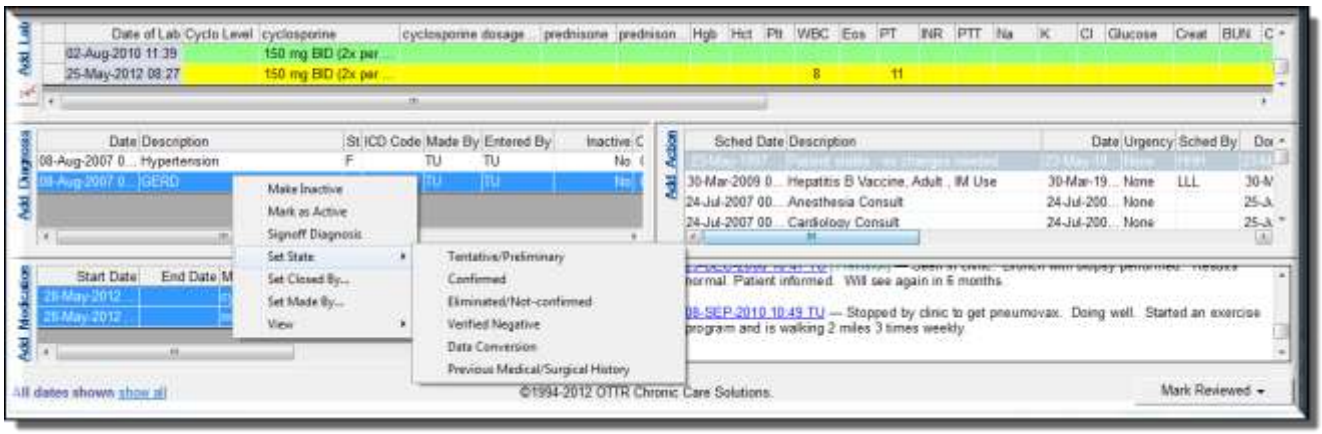


You can change the state of a diagnosis by selecting the diagnosis and utilizing right-click to display the selection options. The user may select:

- Confirmed
- Data Conversion
- Eliminated/Not Confirmed
- Previous Medical/Surgical History
- Tentative/Preliminary
- Verified Negative

To change the diagnosis from active to inactive, select the desired diagnosis and perform the right click option as described above.

To signoff a diagnosis, highlight the desired diagnosis and perform the right click option as described above. Click on the Signoff option.

In addition to the other options, you can also change the view with the right click option to see Active, Inactive or All Diagnoses.


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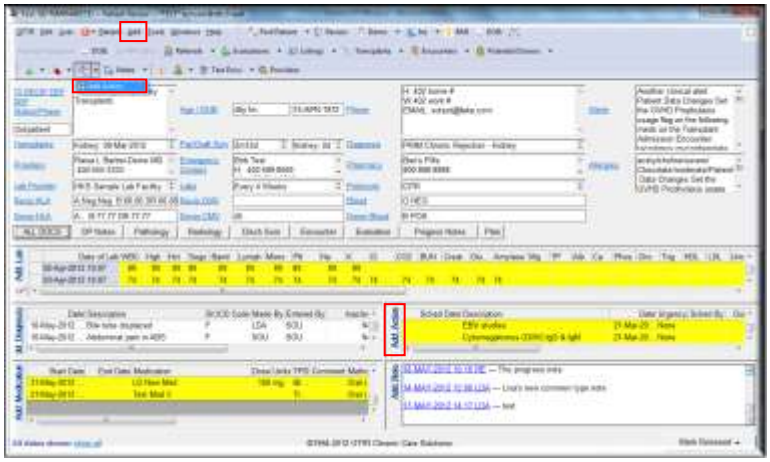
# Actions

This section provides an overview of Actions including how to add an action, scheduling, authorizations, and marking an action as done. It also explains the difference between standard actions and those related to an evaluation.

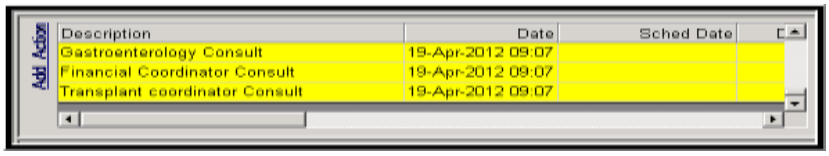
What are Actions?

- Actions represent tasks for the clinical staff
- Actions also represent tests/orders that need to be scheduled and completed
- Actions are used to indicate the status of a Lab or Document review
- Actions are a visual clue as to where the patient is in the transplant process and help to drive your workflow
- Actions can be pulled into a report or letter

Like many areas of the OTTR™ application, there are several ways of entering an action to a patient's record.



The **Actions** icon has a drop-down arrow next to it that allows you to add a new Action




The Add Action hyperlink on the Patient Review window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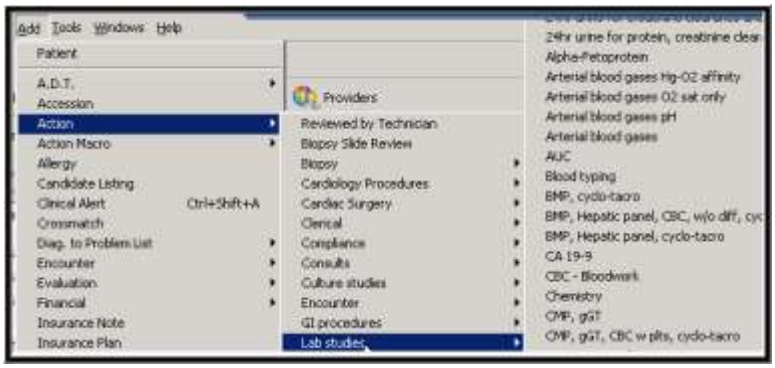
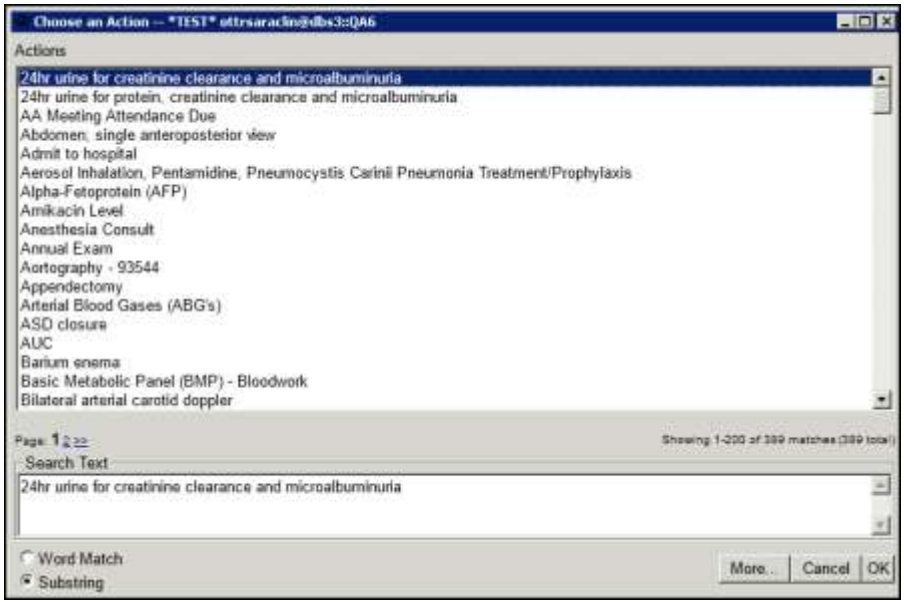
# Adding an Action




From the **Add** Master menu you can select Action, then the category, then the individual action.




Begin typing the name of the action in the **Search Text** field. The displayed list will limit down to what has been typed. Double click on the desired action once it appears or highlight the action and click **OK**. The Action window will open.

**Note:** Remember to use the **More** button and repeat your search if you don't find the action that meets your needs on initial search.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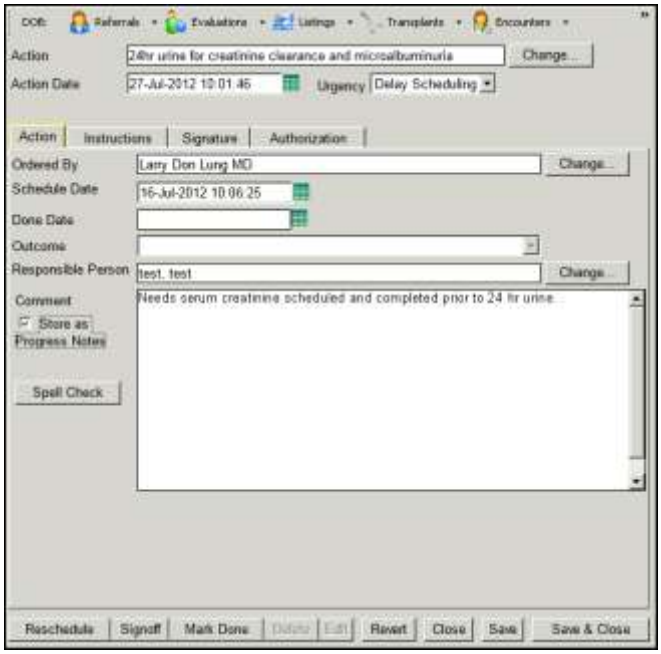
## 1. Action Tab




**Action** – Title of action being added.

**Action Date** – Date the action was added to the patient record.

**Urgency**- Click the drop-down arrow to select the desired level. If you select 'Delay Scheduling', make a note in the comment section indicating the reason for the delay. By marking **Store as a Progress Note**, the comment will display in the notes section on the Patient Review window.

**Ordered By** – Click the **Change** button to select the ordering physician.

**Schedule Date** – Click the **Schedule** button located at the bottom of the window to activate this field. Type in the date and time or use the green calendar to set the date and time. **Note:** It's important to have the correct date and time of a scheduled test if you distribute or use the Patient Calendar .

**Done Date** – To mark an action done, click the **Mark Done** button located at the bottom of the window. This defaults today's date into the field. To change the date click on the calendar icon. Mark the action as done only after you've received the results of the test or consultation, or the patient has arrived for the appointment in the case of a clinic visit.

**Store as Progress Note** – If you place a checkmark in the **Store as Progress Notes** box, once the action has been saved, an **Edit Note** hyperlink will be visible and your comments will display on the Patient Review window. If you select the hyperlink, you'll be re-directed to the corresponding **Progress Note** where you can edit the note and/or send it as an email.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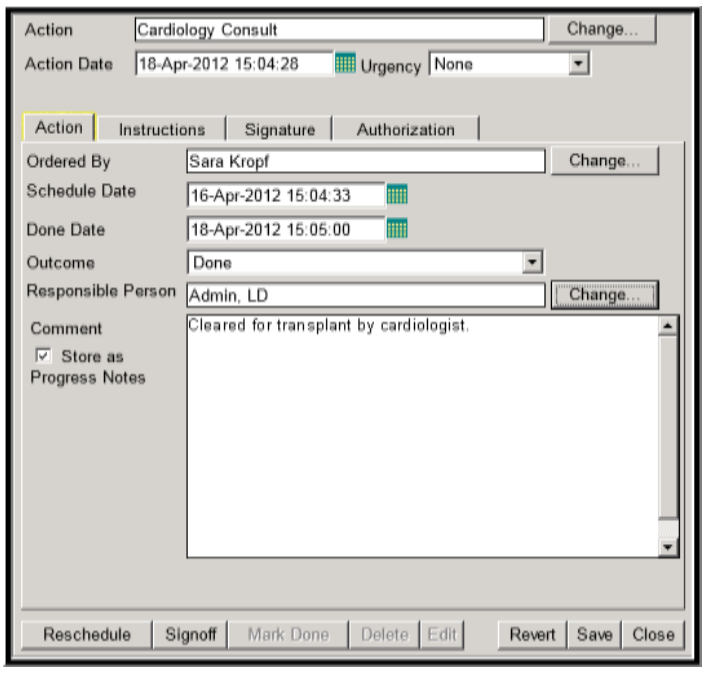


**Outcome** – This area becomes active once an action has been marked done. Click on the drop-down arrow to make a selection.

**Responsible Person** – Click the **Change** button to select the person you wish to assign as the **Responsible Person**. Once assigned, this action displays on that individual's **My Pending Actions** list.

**Comment** – You can free-text a comment regarding this action in the comment box. **Note:** During the evaluation phase, many sites choose to paste the abbreviated results or impression of the ordered action in the comment field area. This will populate on the evaluation report and assists in presenting the patient during selection committee meetings.

**Spell Check:** This area allows you to check the spelling of your comment. Select the Spell Check button and OTTR will display any blocked and misspelled words.

The **Reschedule** button at the bottom becomes active once the test has been scheduled. Click the **Reschedule** button in the event the test needs rescheduled to activate the **Schedule Date** field.


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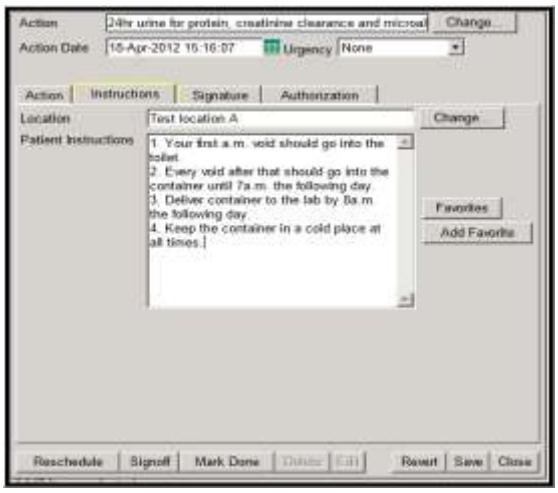
## 2. Instructions Tab



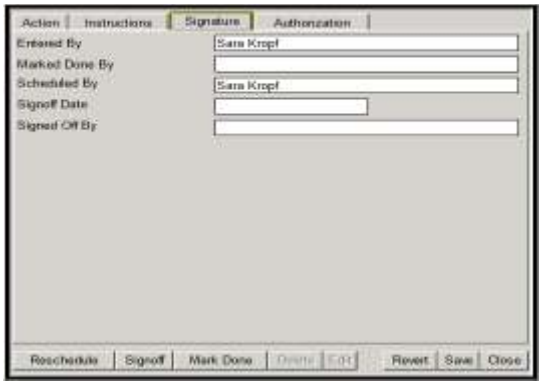

**Location** – Click the **Change** button to select the location where this action is to be completed.

**Patient Instructions** – Enter the instructions desired.

**Favorites**– If the instructions written will be used for other actions in the future, click the **Favorites** button to save the instructions.

**Add Favorites** – To enter instructions which have been previously added to your favorites list, click the **Add Favorites** button.

## 3. Signature Tab




**Entered By** - Displays the name of the person who entered the action.

**Marked Done By** - Displays the name of the person who marked the action as done.

**Scheduled By** - Displays the name of the scheduler.

**Signoff Date / Signed Off By -** This tab is utilized at sites that require a physician sign-off on actions. To sign-off an action the physician must select the **Signoff** button. Their name will display in the **Signed Off By** field and the **Signoff Date** field will display the date of signoff.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## 4. Authorization Tab

Financial personnel can utilize this tab to document information about the authorization number provided by a patient's insurance provider. Some sites won't schedule certain actions (tests) until an authorization number has been entered or a comment has been made stating to do so. Each site determines their own workflow and how they wish to utilize the features in OTTR™.

**Authorization Date** - Enter the date that the authorization starts.

**Payer** - Use the **Pick** button to select from the appropriate insurance company.

**Authorization Number** - The authorization for the test, procedure or transplant phase is entered here.

**Authorization Comment** - Use this area to free text any additional comments.


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## Standard Actions

You can highlight multiple actions within the list and utilize your right-click functions here. HUGE time saver!!

Standard actions are actions ordered for a patient which are not ordered as part of an Evaluation.

Actions in OTTR™ are monitored through patient lists and help drive your workflow. Standard actions that are ordered for a patient will display in Yellow on the **Actions – Pending Unscheduled** list. The individual responsible for scheduling will use this list to schedule the standard patient actions. The ordering person may enter a comment to clarify how an action needs be scheduled or if a specific provider has been requested. Once an action has been scheduled, select the **Refetch** button and that action will fall off the list.

The **Actions – Pending Actions Not Done List** is for actions that have a scheduled date but have not been completed. They display Blue until marked done . Clinicians monitor this list by the date scheduled to determine if results are missing or if patients have missed a scheduled appointment.

The **Pending Actions-All** List displays actions not scheduled and not marked done all on one list.

**Limit tab** - allows you to enter parameters to limit your list.

**Data tab** - displays the list information.

**Description tab** - supplies a description of how the list is populated and cleared.

**Tracking tab** - allows you to add the list to your tracked lists to be displayed in your Message of the Day window.

Columns in the list can be sorted by column header or moved using click and drag functionality.


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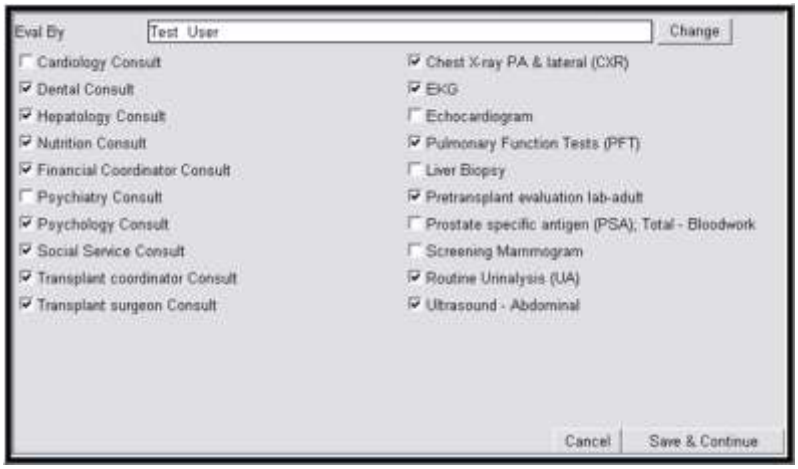
## Evaluation Actions




Evaluation actions are ordered specifically for a patient's Evaluation for transplant or ventricular assist device. When adding an evaluation, an **Order Set** window appears allowing the transplant or VAD coordinator to select or de-select the required actions for the patient.

These actions display on the **standard actions lists**, as well as on the **Actions - Pending Pre-Testing Eval-Unscheduled** list and utilized by the scheduler. Once scheduled, the actions fall on the **Actions - Pending Pre-Testing Eval-Not Done** list until completed and marked done. This allows you to view just the actions associated with the evaluation if needed. Once the items on this list are completed and marked done, the clinician can present the patient at their upcoming selection committee meeting.

**Note:** Refer to the *Lists and List Functionality* document for detailed list management.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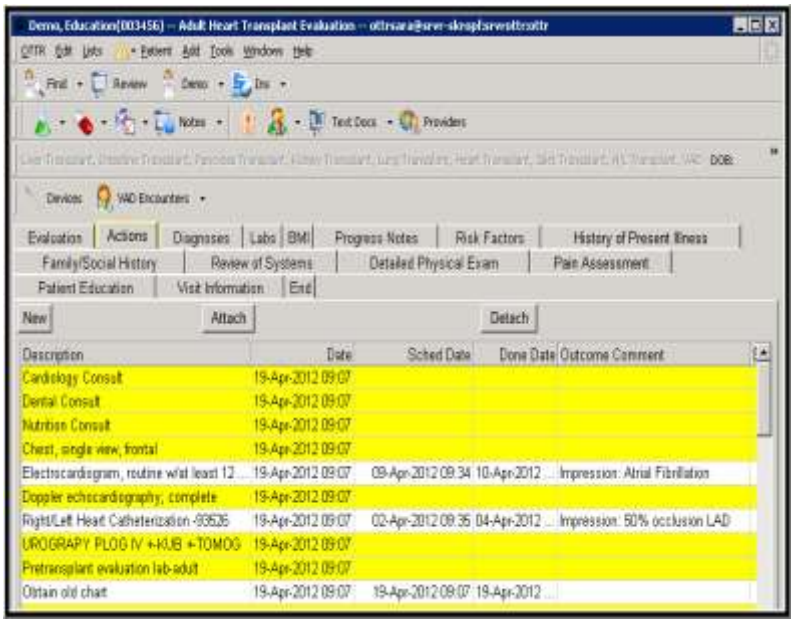
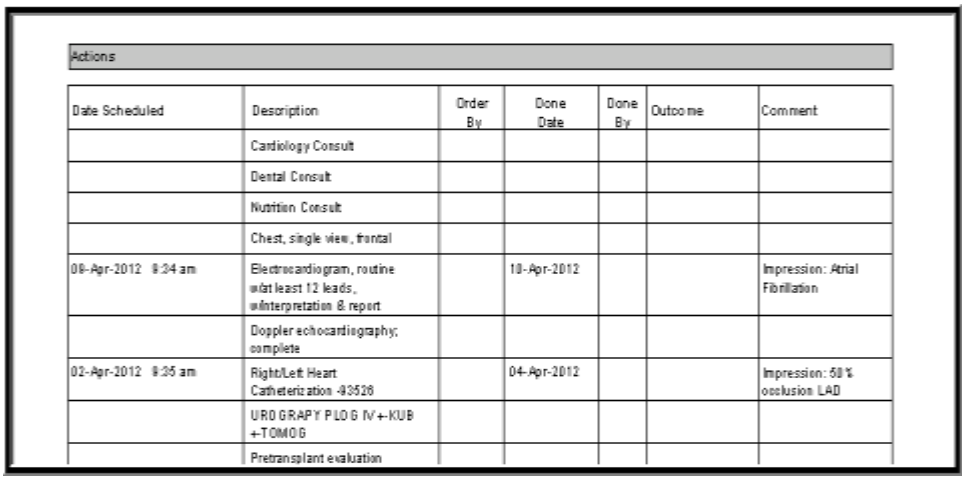
# Evaluation Report



Actions

| Date Scheduled | Description | Order By | Done Date | Done By | Outcome | Comment |
|---|---|---|---|---|---|---|
| | Cardiology Consult | | | | | |
| | Dental Consult | | | | | |
| | Nutrition Consult | | | | | |
| | Chest, single view, frontal | | | | | |
| 09-Apr-2012 9:34 am | Electrocardiogram, routine w/at least 12 leads, w/interpretation & report | | 10-Apr-2012 | | | Impression: Atrial Fibrillation |
| | Doppler echocardiography, complete | | | | | |
| 02-Apr-2012 9:35 am | Right/Left Heart Catheterization -93526 | | 04-Apr-2012 | | | Impression: 50% occlusion LAD |
| | UROGRAPY PLOG IV +-KUB +-TOMOG | | | | | |
| | Pretransplant evaluation | | | | | |

After adding an evaluation for transplant or ventricular assist device, the actions that are ordered and attached to the evaluation will display on the Evaluation Report. As actions are completed during the evaluation process, many sites will copy and paste the final impression of the test into the comment section of the action. This allows you to quickly view the test result on the Patient Review window, and it prints on the evaluation report next to the action. You'll have access to the full detailed results under Text Docs if needed.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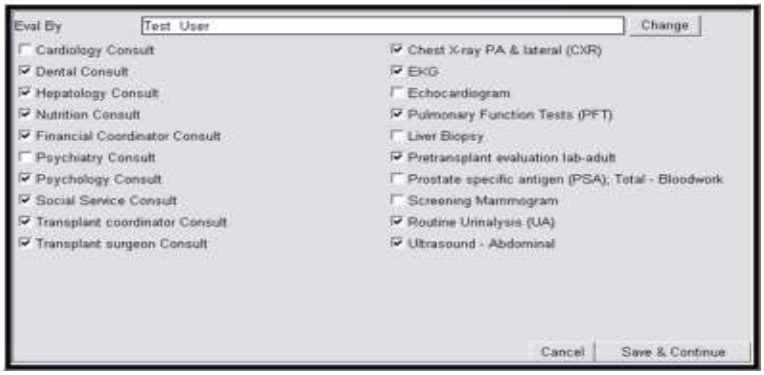
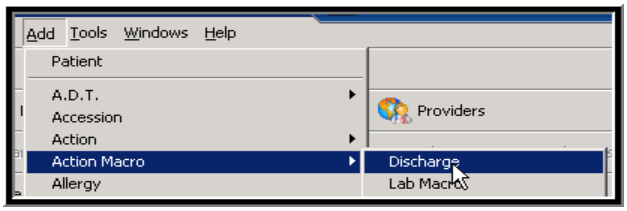
# Order Sets

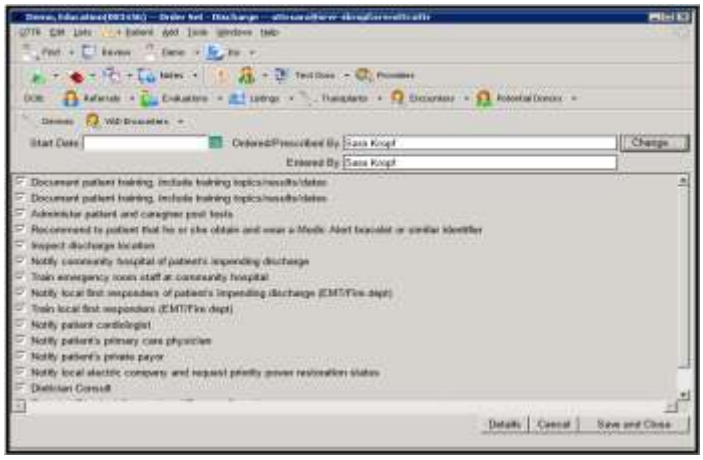



Order Sets, or action macros, are a group of actions, medications or a combination of both. These items are entered on one form and are then distributed throughout the patient's record. Examples include discharge, referral, prednisone taper, etc.

Access them through the **Add** Master Menu, select **Action Macro** or **Medication Macros,** then the order set of your choosing. Clinicians who repeatedly order the same actions for a specific type of visit may request that an action order set be created listing the most common actions ordered for a visit type.

The Order Set can either be entered in **Simple Mode** or in the Original Order Set mode which is a more detailed form.



**Start Date** – Use the **Green Calendar** button to modify the start date. All actions will start on the selected start date.

**Ordered/Prescribed By** – Defaults to the users name. Use the **Change** button to modify the field.

**Entered By** – Displays the name of the clinician entering the macro.

Click the **Details** button near the bottom of the window to open a the detailed view and customize any of the actions in the macro.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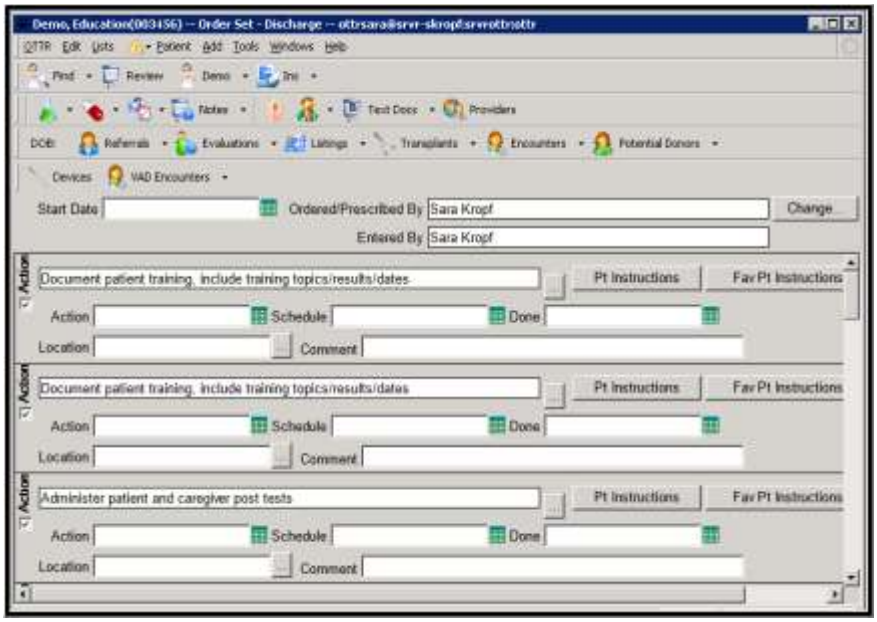


This **Order Set** window allows you to customize the actions in the action macro.

Un-check the **Action** box on any actions you don't want added to the patient's record.

**Action** – This field populates with the date entered in the **Start Date** field above. You can modify the date you want the action to start using the **Green Calendar** button next to the field.

**Schedule** – If you know the date that the action is scheduled to occur, you can enter the schedule date and time using the **Green Calendar** button. Otherwise this will be left blank until the action is scheduled.

**Done** - This field will be left blank until the action is completed and marked done.

**Location** – Modify the location where the action is to occur using the button next to the field.

**Comment** – Add any comment in this field.

**Pt Instructions** – Click to enter any instructions for the patient.

**Fav Pt Instructions** – Click to view any saved favorite instructions, then add the appropriate instructions from the list.

**Save & Close** when you're finished.


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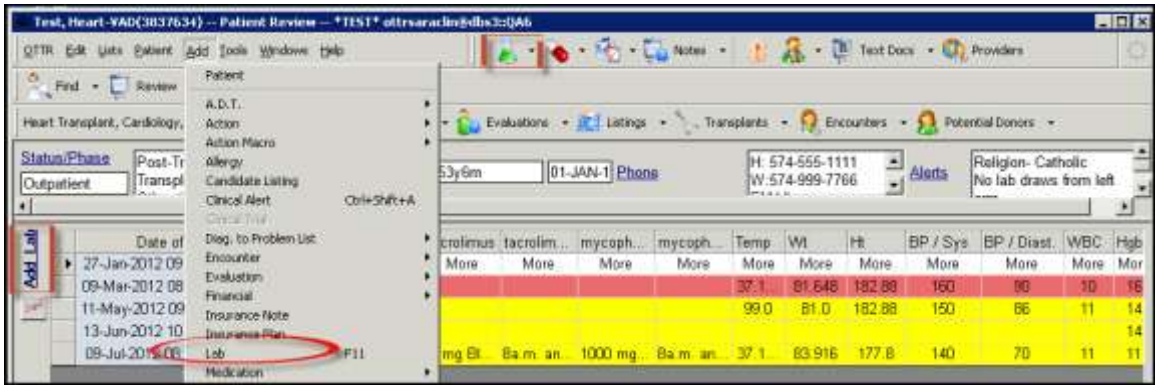
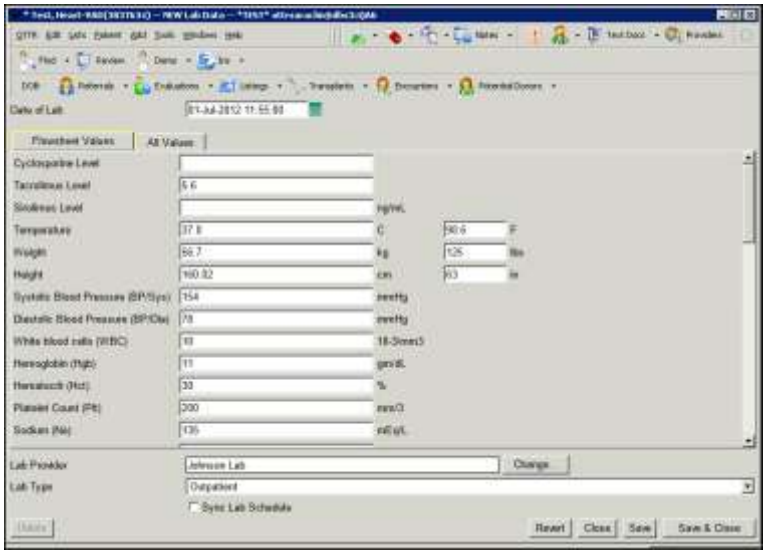
# Labs

This section explains the difference between interfaced labs and manual lab entry. It also details how to mark a lab as having been reviewed, to enter lab results, and how to graph the results. Although the majority of your labs should be automatically populated in OTTR™ through interfaces, there are some labs that may require manual entry.

Labs results are grouped and displayed on flowsheets which can vary by the type of phase the patient is in, pre -transplant vs. post-transplant, or by the lab type such as CBC, Chem 7 ,etc.

If you need to enter a lab result to a patient's record, you can utilize the Add Lab hyperlink on the Patient Review window, the **Add Master** Menu or the **Add Lab** option from the Lab Icon drop down.



**Date of Lab:** Select the calendar to enter the date and the lab was completed. You may also type in the date or use your +/-1 function. This information should match the date and time on the physical copy of the lab results sheet.

**Lab fields:** Manually type in the appropriate results.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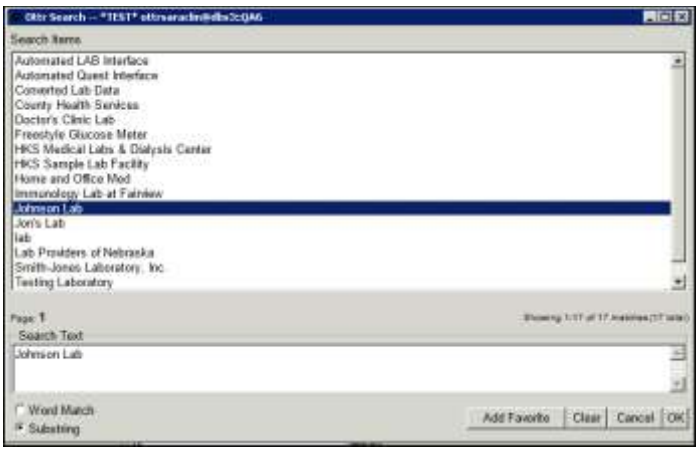
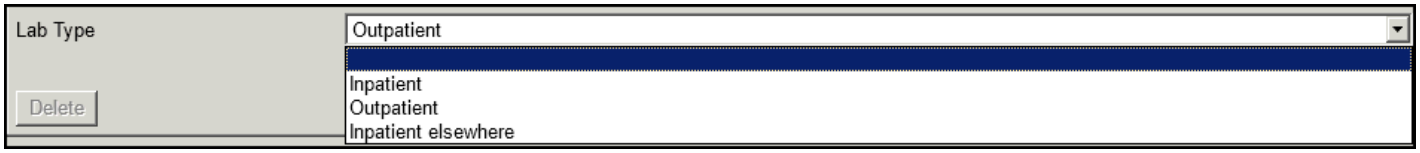
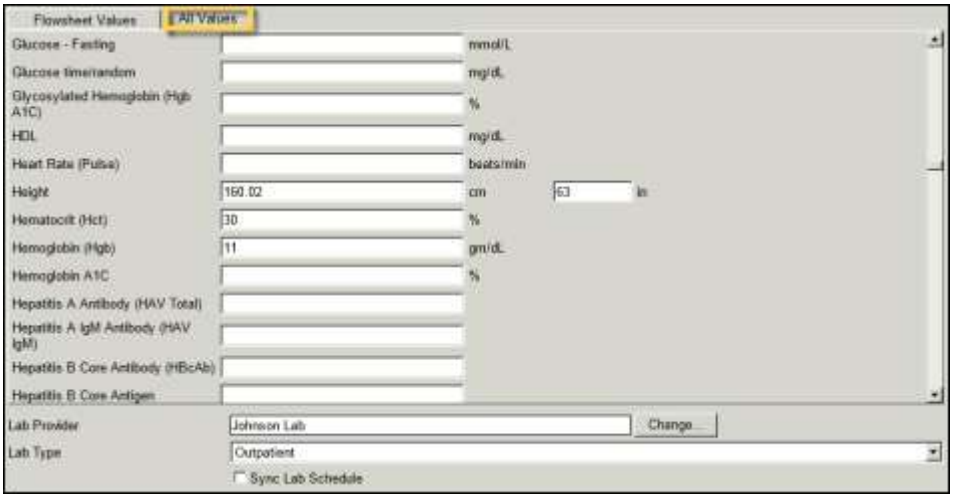



**Lab Provider:** Select the **Change** button to choose the lab provider. This is required prior to saving.




**Lab Type:** Select the drop-down arrow to select the lab type. This is required prior to saving.

**Flowsheet Values Tab:** Fields displaying on the Flowsheet Values tab are labs that belong to that particular flowsheet. In the instance above, it's the flowsheet that displays on the Patient Review window.




**All Values Tab:** The **All Values** tab displays all lab fields currently available in the database, listed in alphabetical order. New lab fields may be added to OTTR™ by the administrator if needed.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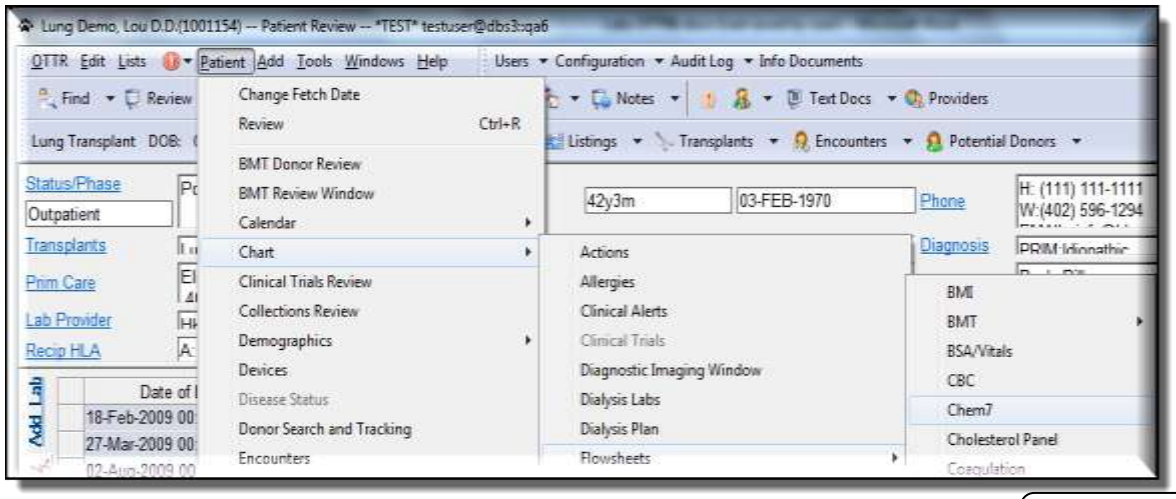
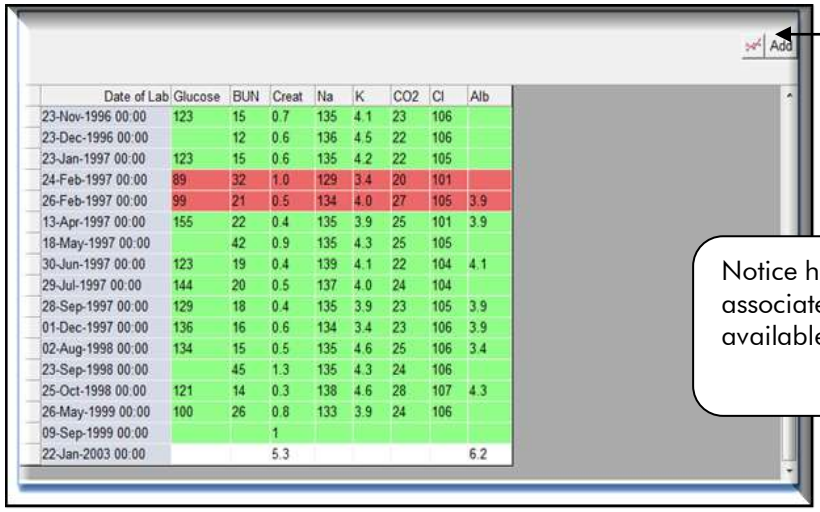
## Flowsheets

If entering external labs, the easiest way to do so is to enter them through a flowsheet. Only fields defined for that type of lab grouping will display in the entry screen. To enter labs on a flowsheet the select the **Patient** Master Menu, select **Chart**, select **Flowsheet,** then select the desired Flowsheet type.




Within the flowsheet window select the **Add** button to display the **New Lab Data** window and follow the directions above for entering results.

Once values are entered into a specific flowsheet, such as **Chem 7**, these results may not be displayed on the **Patient Review** window if they aren't configured to display on that flowsheet. The flowsheet displayed in the **Patient Review** that may vary based on the patient's Program, Treatment Phase and Patient Status.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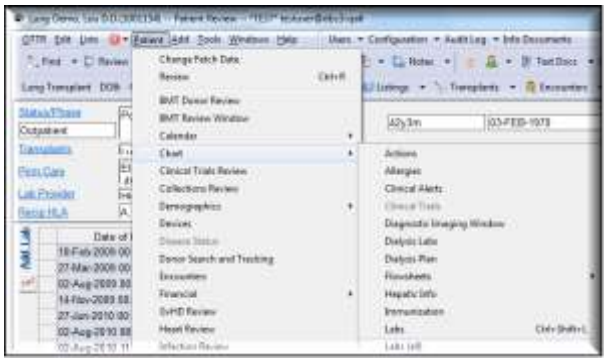
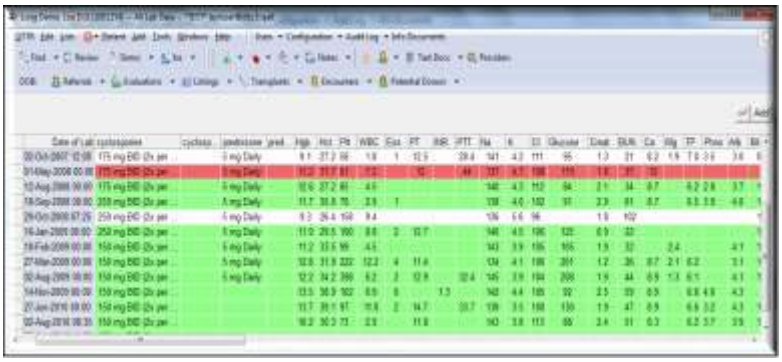
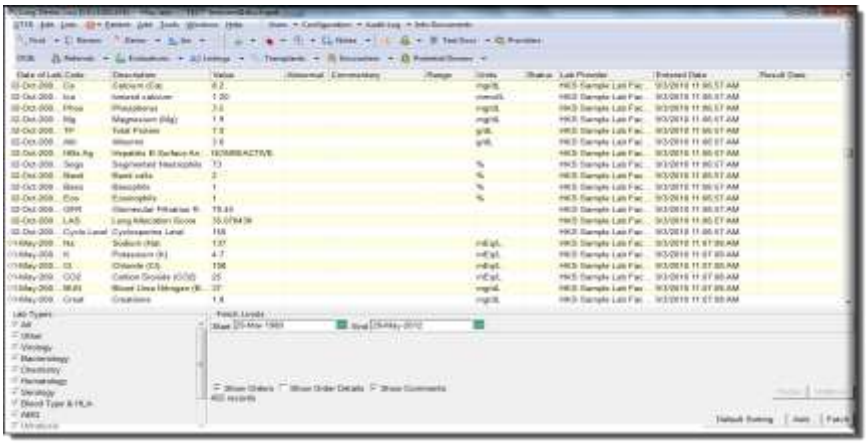
## Labs All





To see all labs associated to a patient's record select the **Patient** Master Menu, select **Chart**, then select **Labs (all)**. This will display all entered labs that have an associated patient labs field.

## Misc Labs



In the event that you don't find an expected lab either on the main Patient Review window flowsheet or in the Labs(all) area; the **Misc Labs** should be checked. **Misc Labs** holds all lab results whether they have been hand-entered or interfaced. Misc Labs consist of results and comments. In the event that you locate the result in **Misc Labs**, you'll need to contact your OTTR™ Administrator so that the lab can be properly mapped to the flowsheet. The easiest way to access **Misc Labs** is by utilizing the **Labs** icon dropdown.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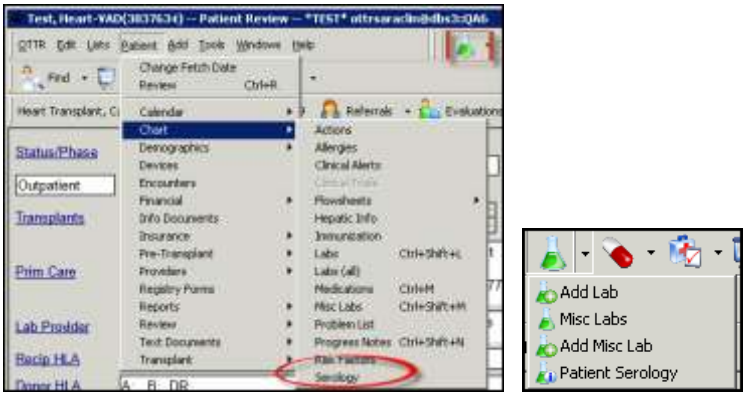
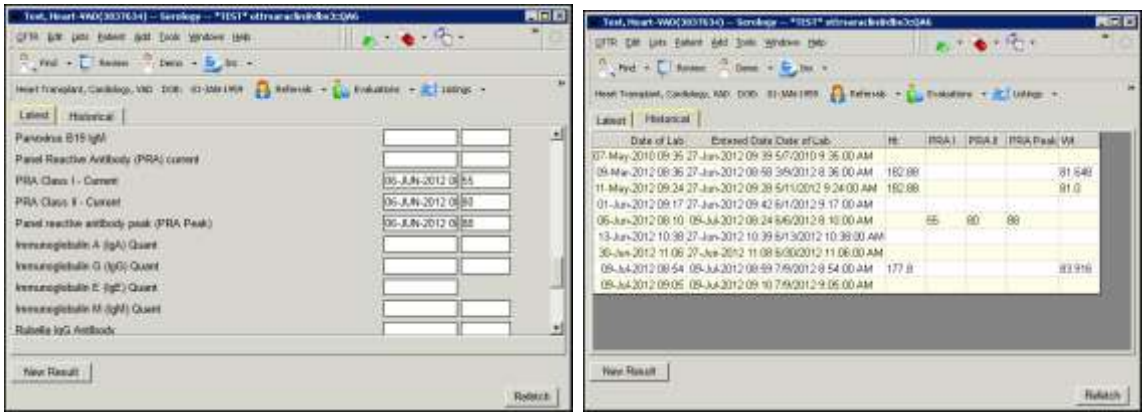
The **Fetch Limits** area of the window will allow you to select a specific date range for the result/s you are looking for. The Lab Types area allows you to select the type of lab you wish to see (all are checked by default). Sorting can also be accomplished by selecting the column headers.

## Patient Serology




Access serologies using the dropdown next to the **Lab** icon, or from the **Patient** Master Menu, select **Chart**, select **Serology**.



The **Serology** flowsheet has 2 tabs, **Latest** and **Historical**. The **Latest** tab shows the most recent results. The **Historical** tab shows all of the values that have been entered on this flowsheet. To enter a new result, select the New Result button at the bottom of either window. The **Refetch** button act will refresh the screen after looking for any new entries.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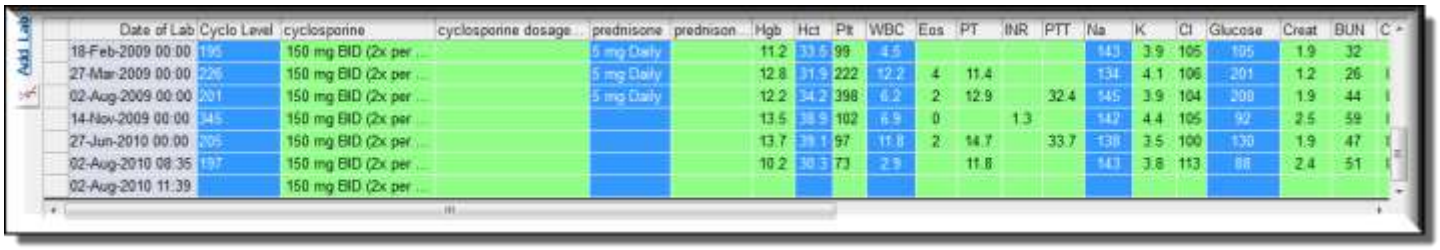
## Lab Graphing

If you would like to see a graphical view of a selection of labs, you can do so from any flowsheet that has the graph icons icon available.

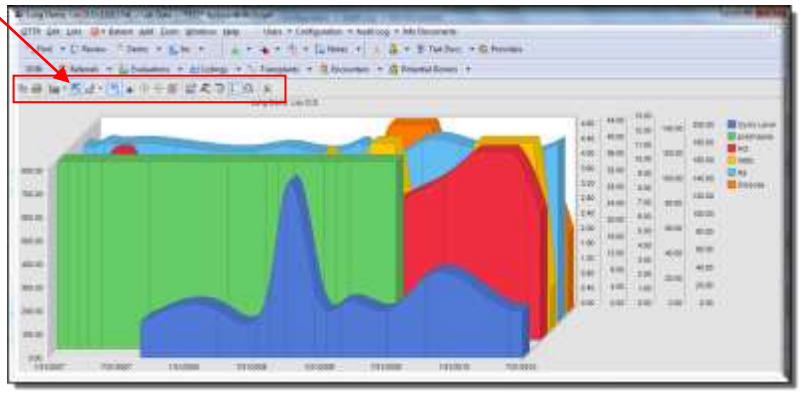


| Date of Lab | Cyclo Level | cyclosporine | cyclosporine dosage | prednisone | prednison | Hgb | Hct | Plt | WBC | Eos | PT | INR | PTT | Na | K | Cl | Glucose | Creat | BUN |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 18-Feb-2009 00:00 | 195 | 150 mg BID (2x per ... | | 5 mg Daily | | 11.2 | 33.6 | 99 | 4.5 | | | | | 143 | 3.9 | 105 | 105 | 1.9 | 32 |
| 27-Mar-2009 00:00 | 226 | 150 mg BID (2x per ... | | 5 mg Daily | | 12.8 | 31.9 | 222 | 12.2 | 4 | 11.4 | | | 134 | 4.1 | 106 | 201 | 1.2 | 26 |
| 02-Aug-2009 00:00 | 201 | 150 mg BID (2x per ... | | 5 mg Daily | | 12.2 | 34.2 | 398 | 6.2 | 2 | 12.9 | | 32.4 | 145 | 3.9 | 104 | 209 | 1.9 | 44 |
| 14-Nov-2009 00:00 | 345 | 150 mg BID (2x per ... | | | | 13.5 | 38.9 | 102 | 6.9 | 0 | | 1.3 | | 142 | 4.4 | 105 | 92 | 2.5 | 59 |
| 27-Jun-2010 00:00 | 205 | 150 mg BID (2x per ... | | | | 13.7 | 39.1 | 97 | 11.8 | 2 | 14.7 | | 33.7 | 138 | 3.5 | 100 | 130 | 1.9 | 47 |
| 02-Aug-2010 08:35 | 197 | 150 mg BID (2x per ... | | | | 10.2 | 30.3 | 73 | 2.9 | | 11.8 | | | 143 | 3.8 | 113 | 88 | 2.4 | 51 |
| 02-Aug-2010 11:39 | | 150 mg BID (2x per ... | | | | | | | | | | | | | | | | | |

Select the labs you wish to graph by holding down your Ctrl key and selecting the columns of the lab. Once you have selected the labs you want to see, select the graph icon .

Lab columns can also be arranged to your liking. Highlight the column you want to move and use click and drag functionality to move the column. When you exit the application, the columns will revert back to their original order.

The Lab Data window will display the selected labs in a graphical view. You have the ability to select the type of view by utilizing the tools area.

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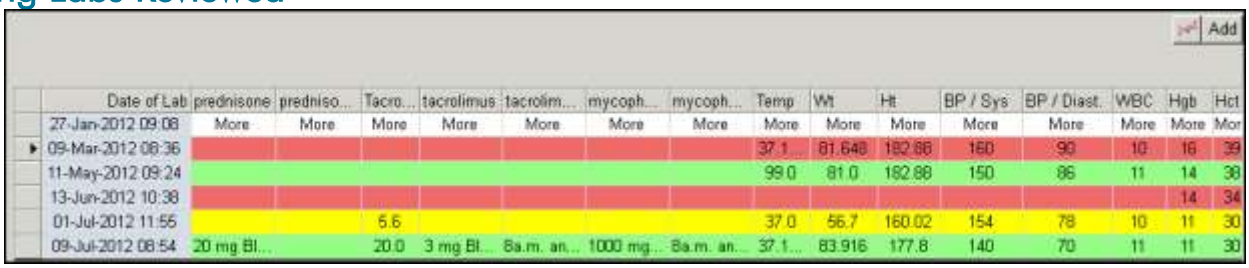
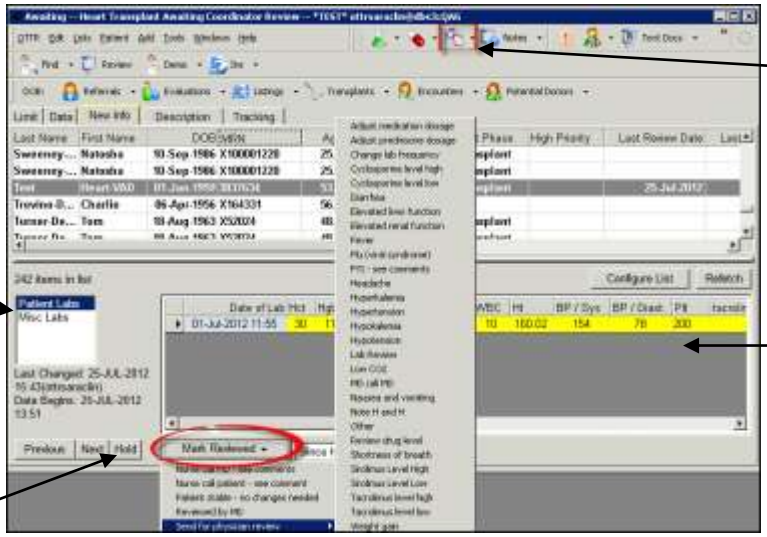
## Marking Labs Reviewed




When labs are received across an interface or are manually entered, they must be reviewed by the transplant coordinator. All new labs will display as yellow until reviewed. Once reviewed, inpatient labs will display as a dark pink, and outpatient labs will display as green.

There are two ways that labs can be marked as reviewed, on the **Awaiting Coordinator Review** list, and the Mark Reviewed button in the bottom of the Patient Review window. You can also mark the patient reviewed from the Patient Review window. There is an option on the bottom-right of the screen called **Mark Reviewed**.

**Note:** Be sure to review all new data before marking the patient reviewed as this not only marks labs as reviewed, but also any new documents or other information that has been entered into the patient record since the last review.


Click here to access the 'mark reviewed' action.
This area will list all items to review. Highlight each area and review prior to marking reviewed.
Information to review will populate here. The information will change depending on what is highlighted to the left.
Hold for lab completion
Mark Reviewed

In the **Awaiting Coordinator Review** list, highlight the row of the patient who's information you want to review. Select the appropriate **Mark Reviewed** option. This will place an action on the patients chart. If you want to add a comment to the action, select the **Actions** icon which will take you to the list of actions for the patient.

If you're waiting on a particular lab to be resulted, you can click the **Hold** button to add the patient to the **Holding for Lab Completion** list. You may have to place this patient on hold several times before all labs are entered which they must review together prior to making a determination and marking the patient as having been reviewed.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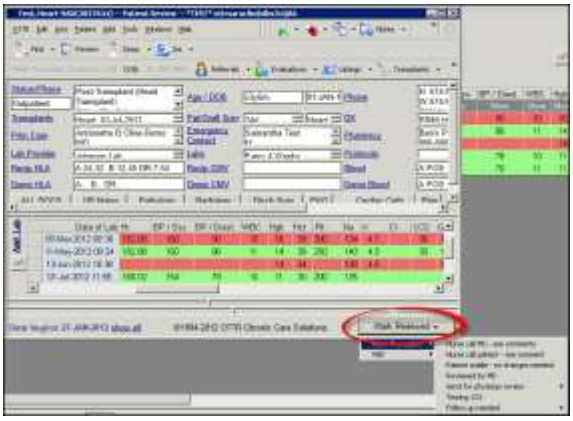
After completing your review, you can exit the list, or use the Previous and Next button to review the next patient's items. Selecting the **Refetch** button will allow the patient to fall off the Awaiting Coordinator Review list once 'Marked Reviewed'.



In the bottom of the review window, you'll see the same **Mark Reviewed** button and functionality.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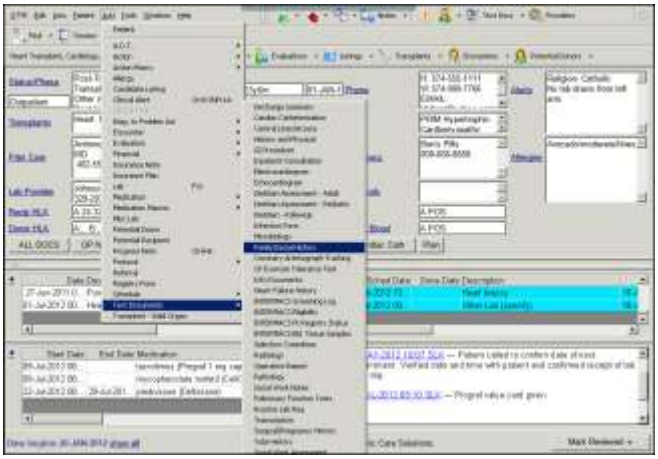
# Text Documents

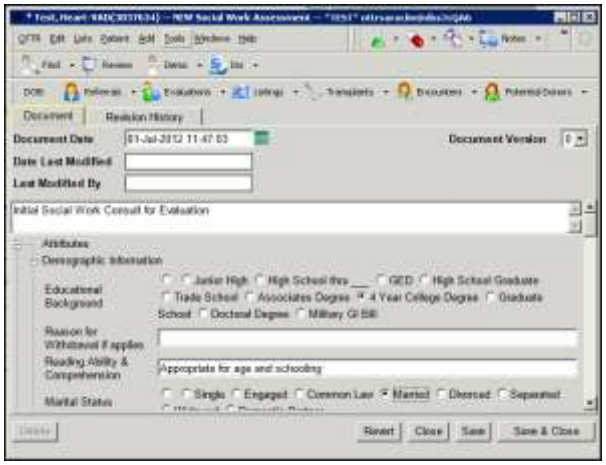
This section explains how to create and attach new text documents and how to review existing text documents within a patient record. If an interface such as Pathology or Radiology is present, text documents are created when the report is sent across an interface. They may also be designed to match your facility's standard forms allowing you to document manually on the form and track the forms electronically. Signed consent forms and written insurance approvals will be scanned and attached to a patient record through Text Documents.

Text documents can be added using the

icon or from the **Add** Master Menu. To add a new text document select the Add Master menu and highlight Text Documents. Select the type of document you want to add.



The desired text document window opens where the clinician will enter the information to be saved.





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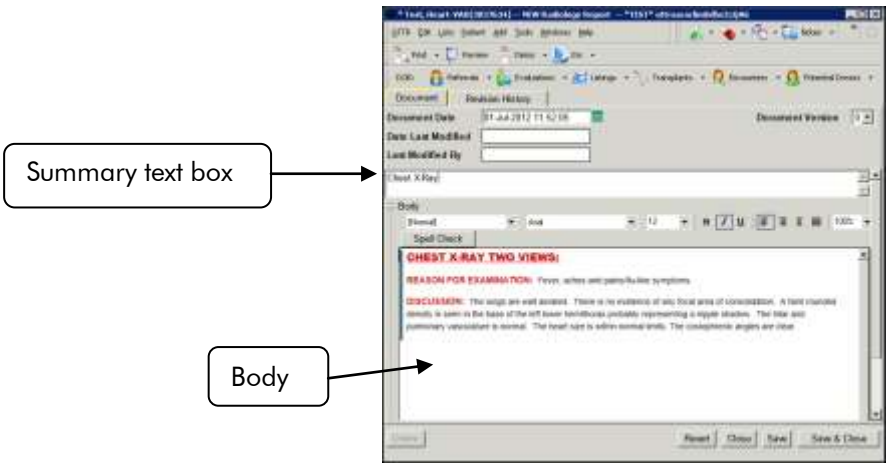
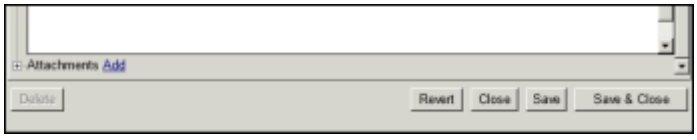



The format of a standard text document consists of:

- **Document Date** – Displays the date the document was created.
- **Date Last Modified** – Displays the date the document was last modified.
- **Last Modified By** – Displays the name of person who last modified it.
- **Revision History** – Displays the number of revisions to the document.
- **Number of attachments** – Displays the number of attached documents.
- **Summary text box** – Users should enter a short summary of what the document contains. This distinguishes reports and assists others when searching for specific information.
- **Body** – Large free text field area for entering content. You can also copy and paste information in this field. For example, if you have a result that you've received electronically, you can copy and paste the impression in the body and then attach the full document using the Add hyperlink.




- **Add hyperlink** – Allows users to attach electronic files to the text document. After selecting Add, choose the document from the folder in which it resides

Note: Fields shown may vary depending upon the type of document selected.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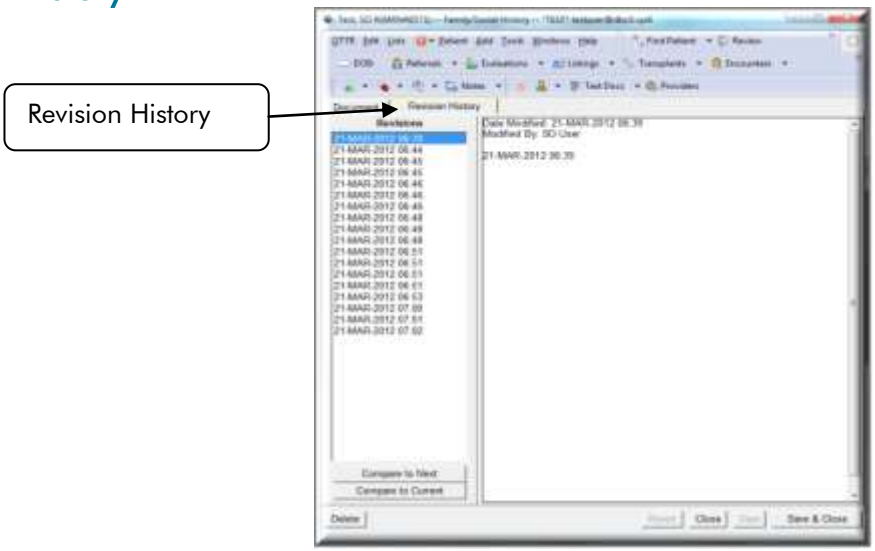
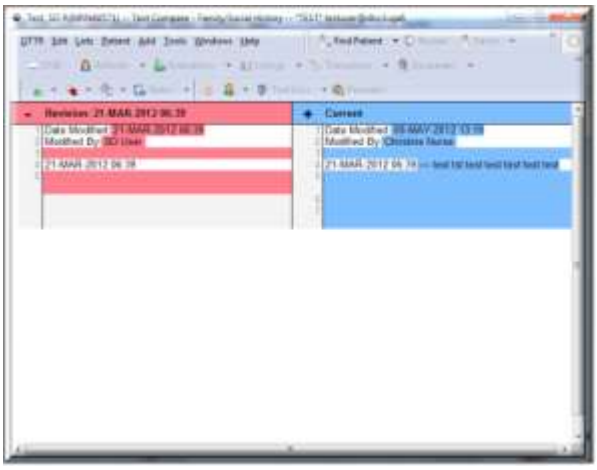
## Revision History




Text documents can be modified or revised and those revisions are tracked. To view a text document's revision history, select the **Revision History** tab. Select the revision you wish to view and click on the **Compare to Current** button. If there are more revisions, you can also select **Compare to Next** which will show the next revision.



What was originally written displays in red (-) and what it was changed to displays in blue (+). You can also see the modified date as well as the person making the modification.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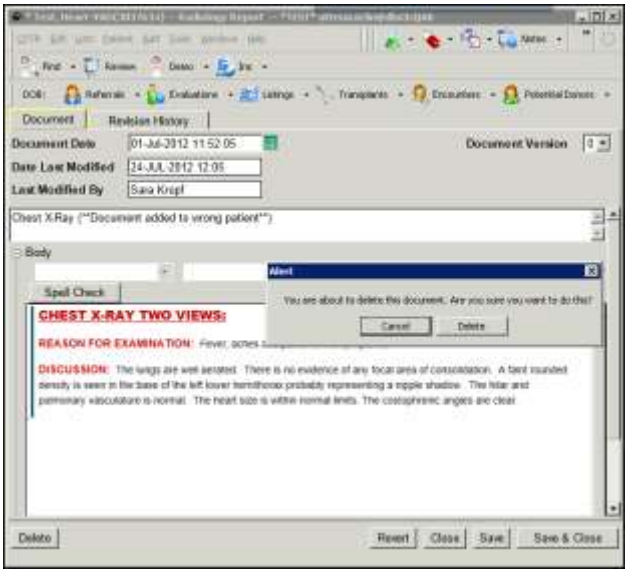
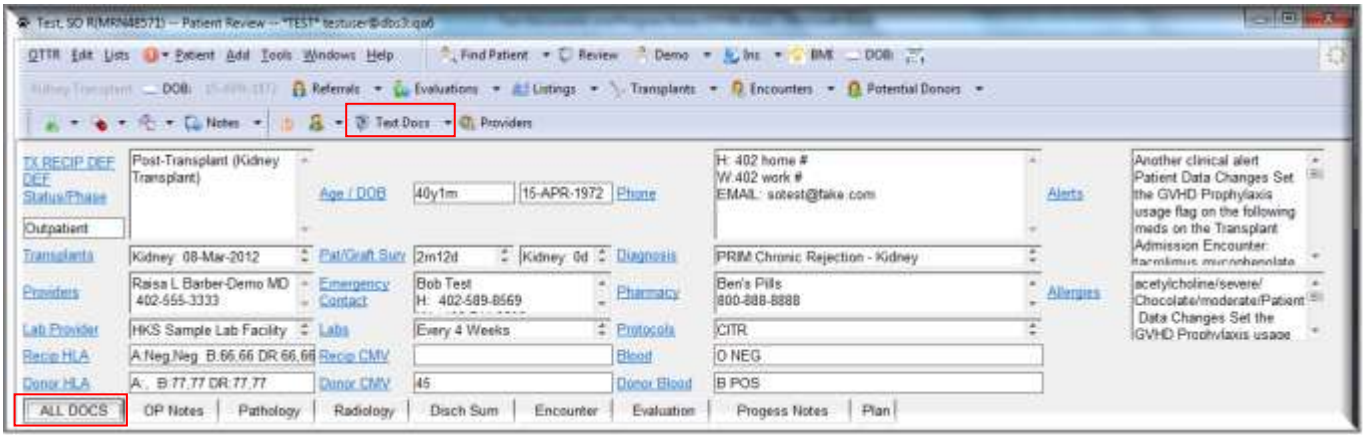
## Deleting and Retrieving Deleted Documents

If a text document is added to the wrong patient record it can be deleted from the clinical view, however, it's not deleted from the patient's record. To delete a text document, open the document and enter a statement in the summary or body of the document stating why it's being deleted. Select the **Delete** option in the lower left corner of the window. You will be prompted to confirm the deletion with an Alert box. Decide whether to **Delete** or **Cancel**, then **Save & Close**.




To review a text document's content, select the **Text Docs** icon or the **All Docs** button on the **Patient Review** window.





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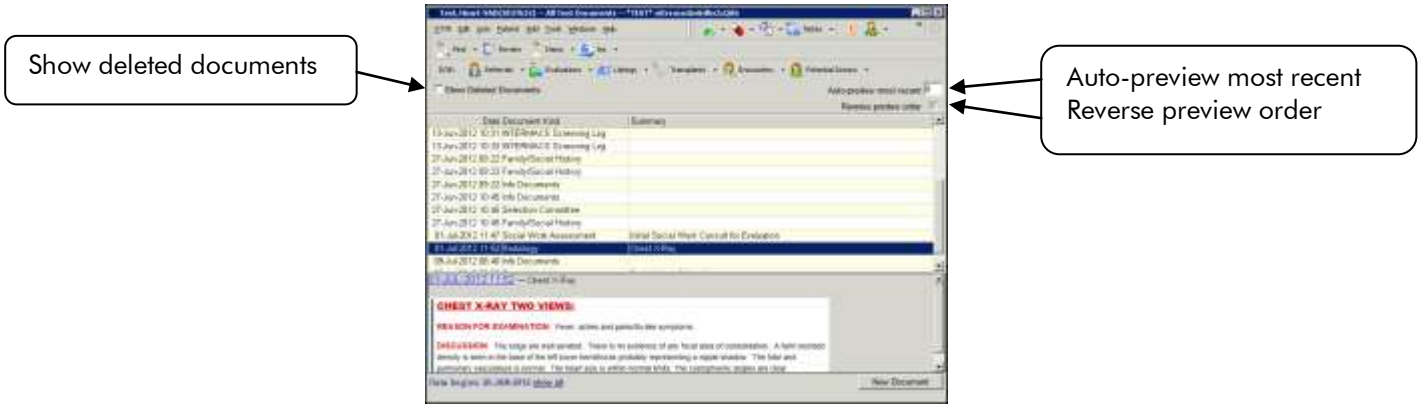
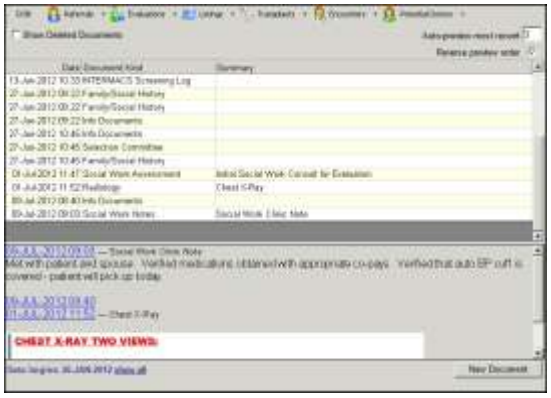
## Viewing Text Documents

Highlight the desired document. You can quickly view information in the contained within the document, in the lower portion of the window, without having to fully open it.




To open the text document, double click on it. Placing a checkmark in the **Reverse preview order** changes the order of the displayed data in the lower portion of this window based upon the document date. Entering an amount in the **Auto-preview most recent** tells the system how many of the most current text documents you wish to display in the lower portion of this window.



To view deleted text documents place a checkmark in the **Show Deleted Documents** box located in the upper left corner of the window.

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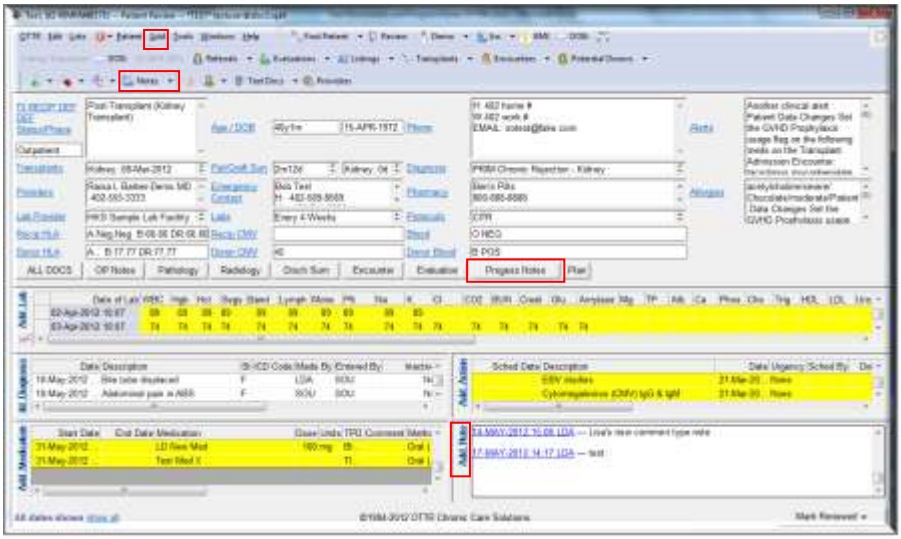
# Progress Notes

This section reviews how to add, edit, revise, delete and email **Progress Notes**. Progress notes can be used for updating staff about patient care, staff communication, or email reminders for certain tasks or updates. Note: If the update involves a phone conversation with the patient, you may want to enter a telephone encounter to document the information vs. a progress note. Once a progress note is written, it can be deleted from the care provider view, but it's not permanently deleted from the patient's record. There are several ways of entering a Progress Note:

- Select the Add Note hyperlink from the Patient Review window
- Select the drop down arrow for the Notes icon then select Add Progress Note
- Or you can select the Progress Notes button on the Patient Review window
- From the Add Master menu, select Progress Note or use Ctrl + N (hold down your Ctrl key and select your N key)



Once you've selected an option for adding a Progress Note, you'll be directed to the **New Progress Note** window.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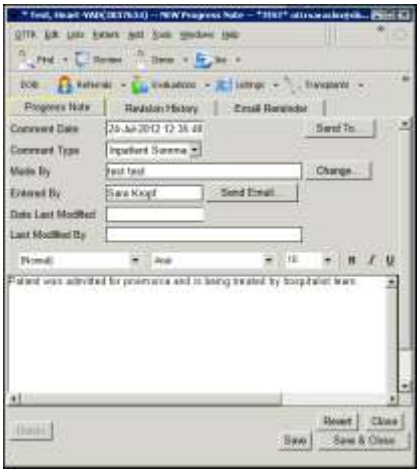
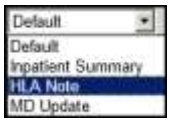
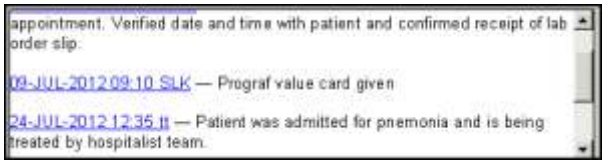
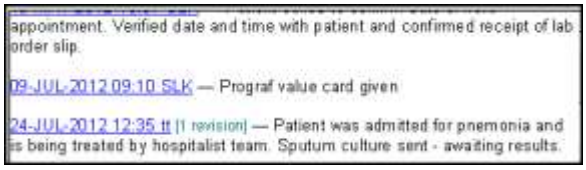





**Comment Type**: Select the drop-down arrow to select the type of progress note which will be entered. This categorizes the notes and allow them to be displayed by comment type. Enter the note in the free-text box provided. Save and Close. You'll see the progress note displayed on the Patient Review window.


appointment. Verified date and time with patient and confirmed receipt of lab order slip.
09-JUL-2012 09:10 SLK — Prograf value card given
24-JUL-2012 12:35 tt — Patient was admitted for pnemonia and is being treated by hospitalist team.


appointment. Verified date and time with patient and confirmed receipt of lab order slip.
09-JUL-2012 09:10 SLK — Prograf value card given
24-JUL-2012 12:35 tt (1 revision) — Patient was admitted for pnemonia and is being treated by hospitalist team. Sputum culture sent - awaiting results.

To edit a Progress Note, select the hyperlink for that note. The hyperlink displays the date, time and care provider's initials who wrote the note. Make the desired edits to the progress note, Save & Close. Notice that the edited progress note now displays as having (1 revision). Select the hyperlink for the progress note to view the revisions made (identical to Text Document revisions).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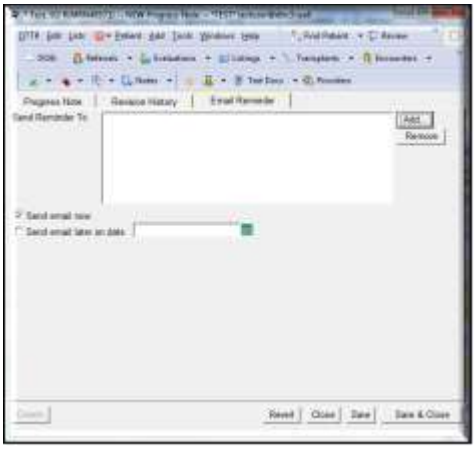
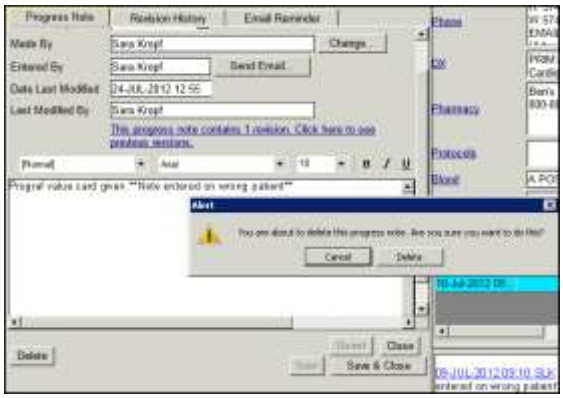
You have the ability to write a progress note and send it as an email reminder. Example: You could write a progress note updating a care provider on the patient's status (medical or financial). To email the progress note, select the Email Reminder tab.



Select **Add** to choose the mail recipient. The **Send email now** field is automatically checked. If you don't want to send it upon saving, deselect this option. To send the email in the future, select **Send email later on date** and enter the date you want the email sent within your hospital's email account. *Note: Both the recipient and sender need a valid email address in order to send/receive mail. The recipient won't be able to reply to the email, the email is only outgoing from OTTR™.

If a progress note is written in the wrong patient record it can be deleted from view. Open the progress note and enter a comment at the end of the note indicating why the note was deleted. You'll then need to **Save & Close**, then re-open the note. Select the **Delete** button. You'll be prompted on whether or not you want to complete the deletion of the Progress Note. Select **Continue** then proceed to **Save & Close**.




To view deleted notes click on the **Notes** icon. Place a checkmark in the **Show Deleted Notes** box in the upper left portion of the window.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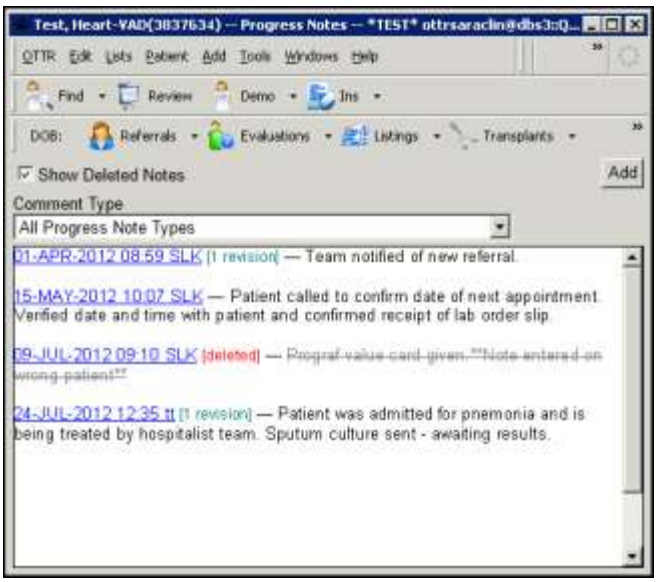
Test, Heart-VAD(3837634) -- Progress Notes -- *TEST* ottrsaraclin@dbs3:Q...
OTTR Edit Lists Patient Add Tools Windows Help
Find Review Demo Ins
DOB: Referrals Evaluations Listings Transplants
Show Deleted Notes
Add
Comment Type
All Progress Note Types
01-APR-2012 08:59 SLK (1 revision) — Team notified of new referral.
15-MAY-2012 10:07 SLK — Patient called to confirm date of next appointment. Verified date and time with patient and confirmed receipt of lab order slip.
09-JUL-2012 09:10 SLK (deleted) — Prograf value card given.**Note entered on wrong patient**
24-JUL-2012 12:35 tt (1 revision) — Patient was admitted for pneumonia and is being treated by hospitalist team. Sputum culture sent - awaiting results.

Notice the deleted note displays with a line through the text. The notes can be additionally sorted by **Comment Type** using the drop-down box to choose a type.


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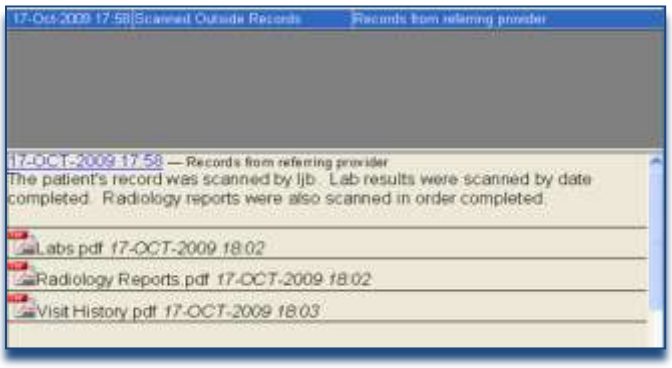
# Scanned Documents

When scanning received outside records it is best to group information being scanned together in a manner which will expedite the review of the documentation. For example, lab results, visit history, radiology reports, or consults.


17-OCT-2009 17:58 — Records from referring provider
The patient's record was scanned by ljb. Lab results were scanned by date completed. Radiology reports were also scanned in order completed.
Labs.pdf 17-OCT-2009 18:02
Radiology Reports.pdf 17-OCT-2009 18:02
Visit History.pdf 17-OCT-2009 18:03

Within the **Summary** or the **Body** of the text document a statement can be made about the received medical records. If key information should be highlighted then make a statement about it within the Summary Line of the text document.

In order to attach scanned documents in OTTR™ you'll need to scan the image or document and save it to a local drive. *See your IT department for scanning/copying.

Once you've saved your scanned item to a local drive, you can attach it to a **Text Document** in OTTR™. Open the document you'd like to attach your scanned item to or create a new **Text Document**. Scroll to the bottom of the window to click on the Add hyperlink. Navigate to where you've saved the scanned document or image. Highlight the desired file and click the **Open** button. Once you see that the document's attached, click the **Save & Close** button.

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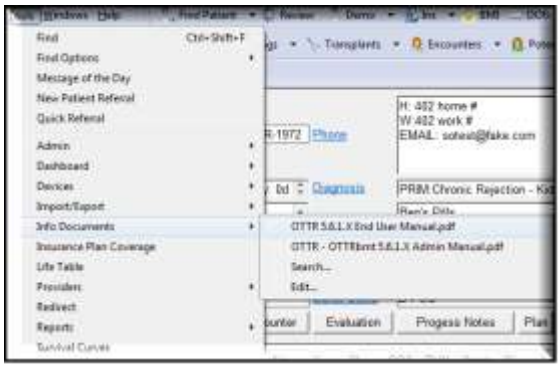
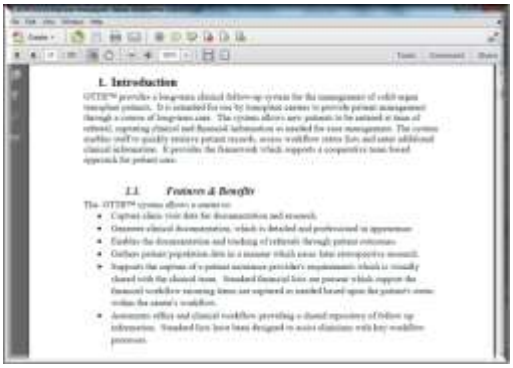
# Info Documents

This section explains how to find and print info documents. Many of your facility's standard documents have been added to OTTR™. These documents may be printed and given to patients for educational or informative purposes, such as a manual or consent form. Utilizing the master menu, select **Tools**, drop down to **Info documents** and select the desired document. The software utilized at your facility to open the selected document will begin to run i.e. PDF viewer.




Confirm the desired document has opened. Click on **File\Print** option in your facility's approved software. The default printer name set for the local computer will display. Click on the **Ok** button to print.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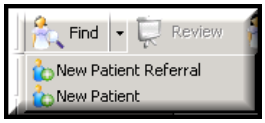
# New Patient Referral




There are two options for entering a new patient into OTTR™ from the **Find Patient** icon. **The New Patient Referral** option is the most efficient way to enter patient specific information without navigating to multiple windows in OTTR™; and is the recommended way to enter a recipient or living donor new referral to your program(s). The referral form is divided into frames. Each frame has a header which defines the type of information being captured.

The **New Patient** option should be used when entering a deceased donor to the system in order to link to a recipient when a transplant occurs.

What does the referral form do?

- It adds a new patient into OTTR™.
- It places the patient into the correct program and creates the referral record.
- It captures insurance information and places the patient onto the financial coordinators Pending Benefits Verification list.
- It allows the user to enter the matching criteria required by the interface server to begin placing results within a patient record.
- It opens the referral record upon the saving and closing of this form.

Once the patient has been added to the database, interfaced results and documents will flow into the patient's record. Depending on the interfaces your site has purchased, OTTR™ can accept incoming messages from your facility's sending systems such as Lab, ADT, Radiology, Pathology and Transcriptions. *Prior to entering the **New Patient Referral**, it's recommended that you search for the patient using the **Find Patient** icon to avoid a duplicate patient entry. If the patient is already present in the system, you would update the demographic information and add a new referral using the Referrals icon.

Select the drop-down arrow next to the **Find Patient** icon and select **New Patient Referral**. *You can also select this option from the Tools master menu.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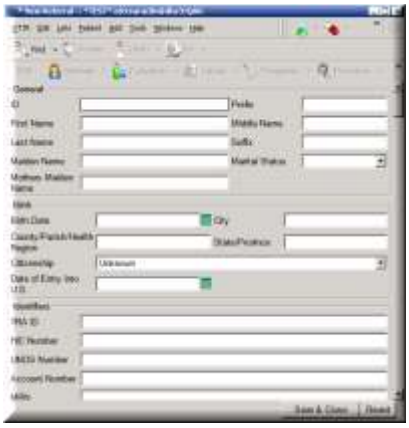
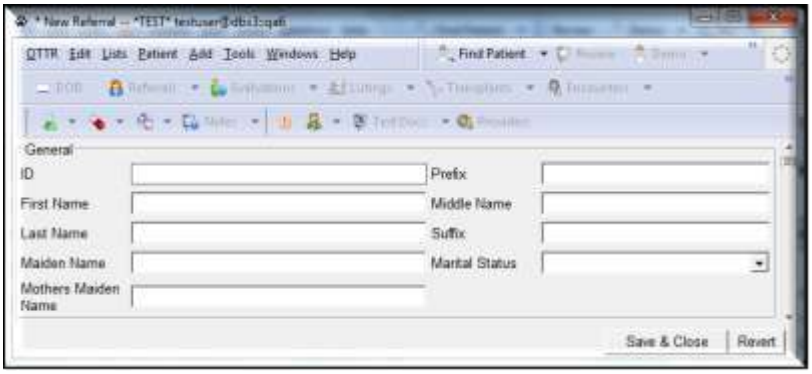


Once you've selected the New Patient Referral option, you will be re-directed to the **New Referral** window.





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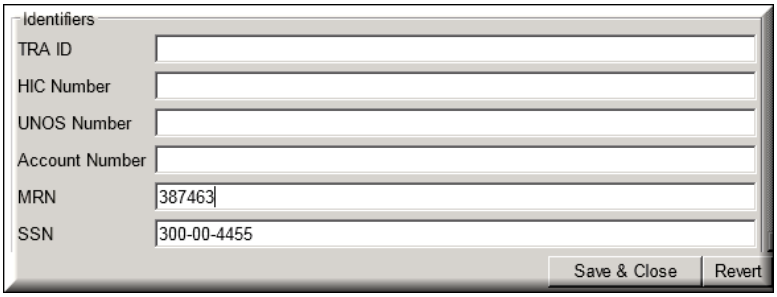
## New Referral Form

The first, or **General** frame is your patient's basic demographic information such as Name, Marital Status and Mother's Maiden Name. *You should enter as much information as possible into each frame, but in the event you are limited on time, the minimum information needed includes name, date of birth, name of referring physician, and assigned program. You'll have to enter the missing patient information at a different time using the demographics, insurance, and care provides icons to complete the record.

The **Birth** frame is where you'll document the patient's date of birth, location of birth and citizenship information.




Following the **Birth** frame is the **Identifiers** frame. Document the patient's MRN, SSN or other site-defined Identifiers that are known.

In the **Programs** frame, place your patient in the appropriate program. If the patient is being referred for more than one type of transplant, place a check in the box next to each applicable program.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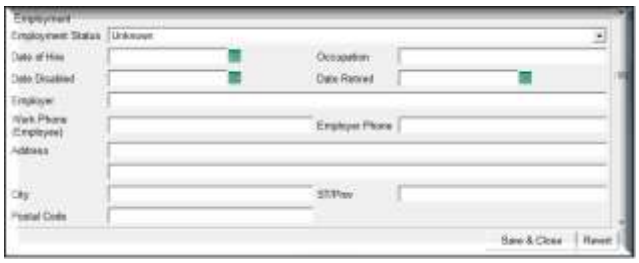


In the **Employment** frame, document the patient's employment status and occupational details.

The **Home Address** frame is for documenting the patient's current address information.

The **Local Temp Address** area is used to document the temporary address for the patient such as a Ronald McDonald house near your facility.

The **Education** frame is to document the highest level of education for the patient and the year in school.


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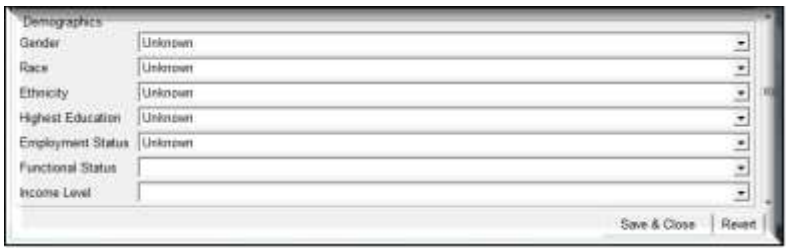
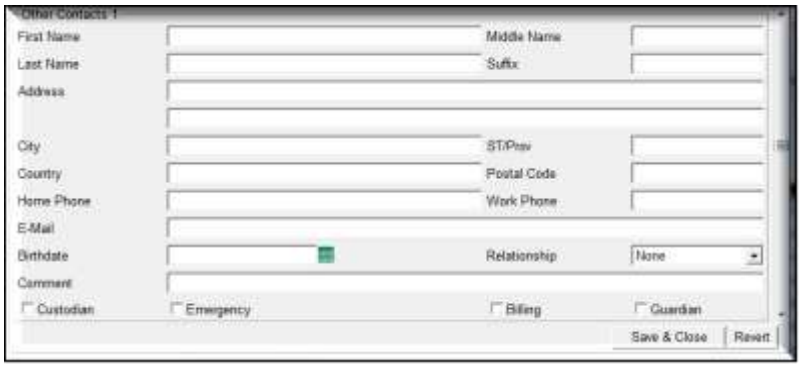
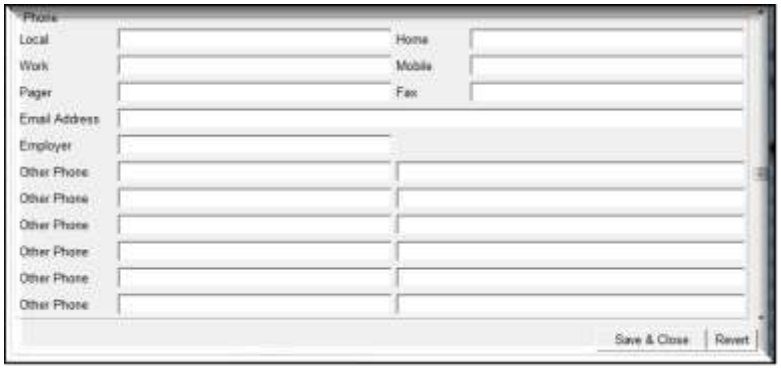



Use the **Demographics** frame to document the gender, race, ethnicity and functional status for the patient using choices that correlate with UNOS data. Utilize the drop-down options for this area. You won't be able to free-text in areas that are designated for drop-down selection.




The **Other Contacts 1** frame is for documenting the patient's next of kin, guardian, power-of-attorney, etc. The following frame is an additional contact frame. Be sure to mark the emergency contact by placing a check in the Emergency box. This allows the information to populate on the patient review window. *Note: If additional contacts need to be added, you can do this in the patient's demographic area.




The **Phone** frame is where you'll document the phone contact information for the patient such as home, work, mobile and pager. There is also an area to document the email address for the patient. You can add additional numbers in the **Other Phone** fields and free text a name or notes next to them.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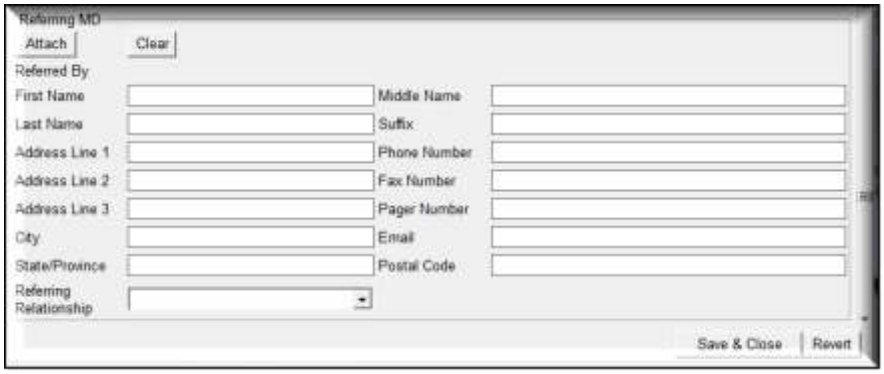
The **Referral** frame is to document the referral date, organ type and the type of referral.

Use the **Referral Diagnosis** frame to document the referring Primary, Secondary and Tertiary diagnosis. Select the **Change** button to open a search window for diagnoses, and select the appropriate diagnosis. *Note: If possible, select the diagnosis that references a UNOS code as this will be the most official diagnosis and is utilized in our Registry tool to complete the Teidi forms. *If the patient is being referred for a multi-organ transplant, put in the diagnosis that correlates with each diagnosis.




The **Referring MD** frame allows you to associate the Referring MD to the patient's record. You can't type into these fields, instead you need to select the **Attach** button to open a provider search window to select the appropriate MD. Once you've selected the Referring MD, also choose the **Referring Relationship** as Referring MD. There are 2 other frames to document additional care providers such as Primary Care or Secondary Referring MD.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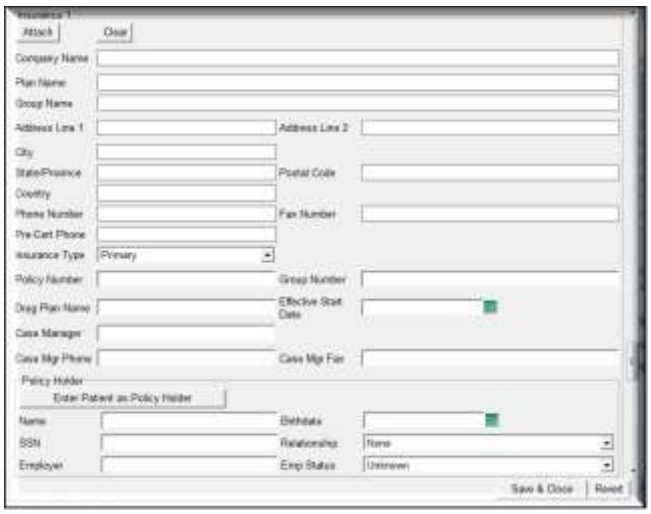
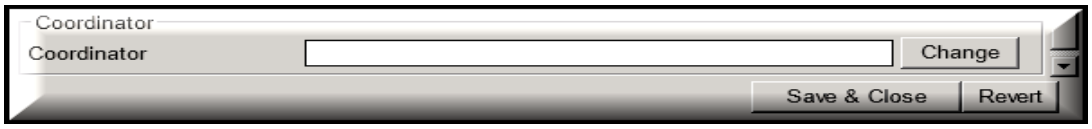



The **Insurance 1** area is where you'll document the patient's Primary Insurance if known. Select the **Attach** button to choose an Insurance Provider and Plan. You can free-text the Policy Number, Group Number, Drug Plan Name and Case Manager information or add them to the Insurance window at a later date. Click the **Enter Patient as Policy Holder** button, if applicable, which auto-populates the information into the blanks if entered in the frame above. The following 2 frames are to document Secondary and Tertiary Insurance Provider.




Use the **Change** button in the **Coordinator** frame to search for and add the primary coordinator for the patient.

The last frame is the **Next window to view** frame. This is where OTTR™ will re-direct you once you have selected the Save & Close. The Referral window is recommended and set as a default so that you can add the referral event to the record. However, you have the option to go to the patient's Demographics, the Patient Review window or OTTR™ can close this screen and not direct you anywhere after entering this information. *Note that the **Revert** button at the bottom of the window clears **all** information that has been entered up to that point when selected.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# Patient Demographics

After entering your referral, you may need to review, add or update information in the patient demographics to complete the record. This section reviews how to access the patient's demographic windows and how to attach or remove digital images.

You can access the Patient Demographics window using the

icon or the Patient Master Menu.

A multi-tabbed patient demographic window opens and offers you the ability to update patient specific demographic information. Information entered here flows throughout OTTR™ and displays automatically whenever those fields are included within an active window. *Note this is the window that opens when you select the New Patient option to enter deceased donor information.

## General Tab

The first tab is the **General** tab. Information that's been entered into the New Patient Referral form will display. You can update information as needed within the various tabs.

**Add a Photo**: Click on the **Add Photo** button and navigate to where you have saved the digital picture. Highlight the desired digital image and click Open. The selected digital image will then display where you see **No photo available**. *Note: A good size to save digital images is 300 X 300 dpi. To remove a photo, select the **Clear Photo** button.


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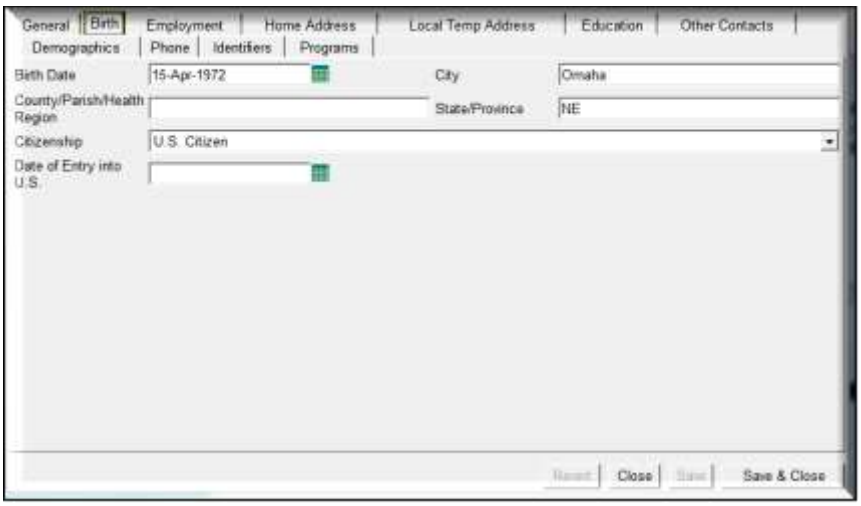
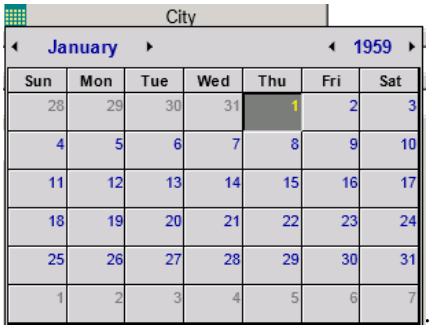



## Birth Tab

The **Birth** tab holds the patient's date of birth, place of birth and citizenship information. Information is entered via free text or drop-down if a black arrow is next to the field . Dates can be entered via free text using the format of mm/dd/yy or using the forward and back buttons in the green calendar  .

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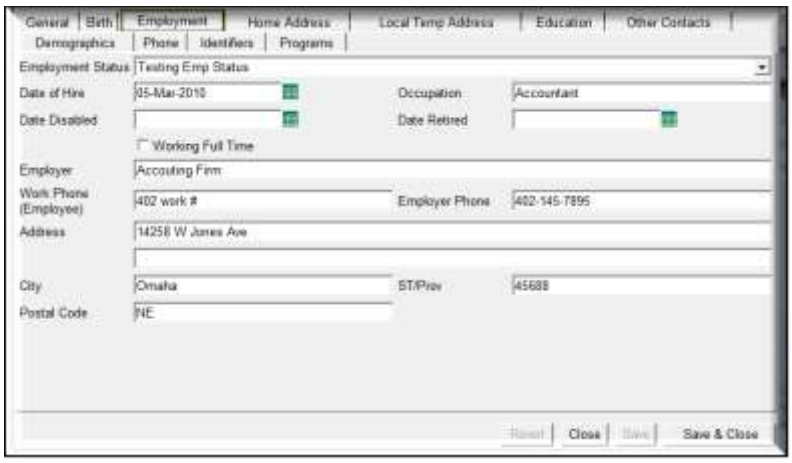
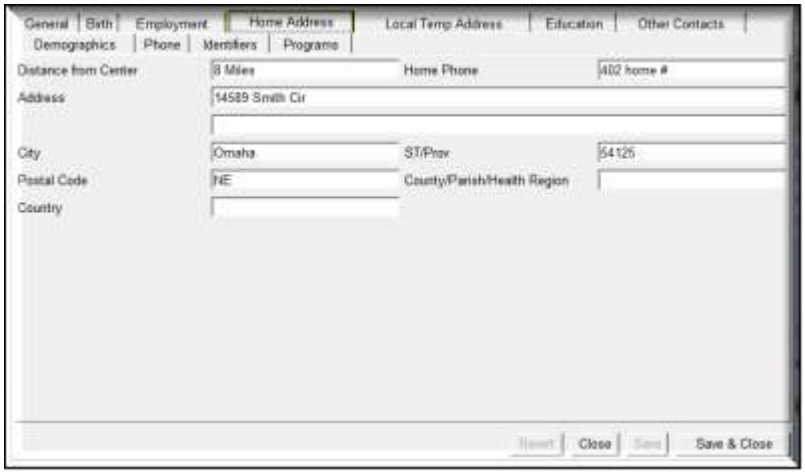



## Employment Tab

The **Employment** tab holds the patient's employment status and, if employed, the employer information.




## Home Address Tab

The **Home Address** tab holds the patient's current address and captures the distance from your facility if entered.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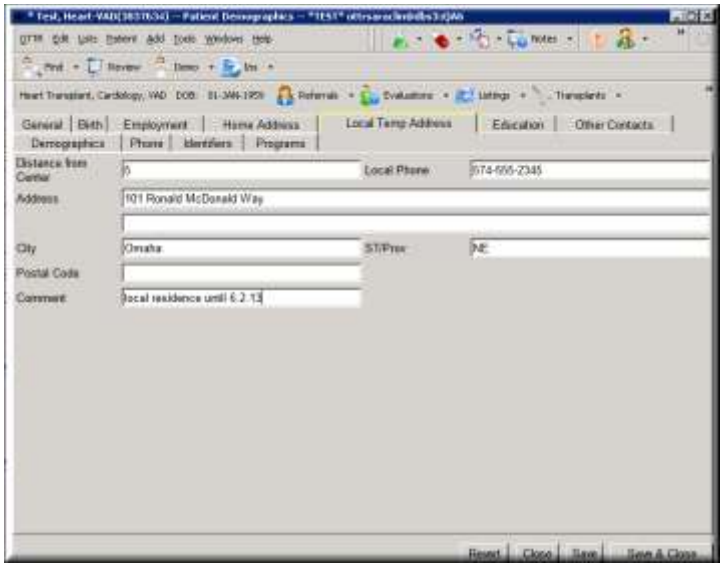
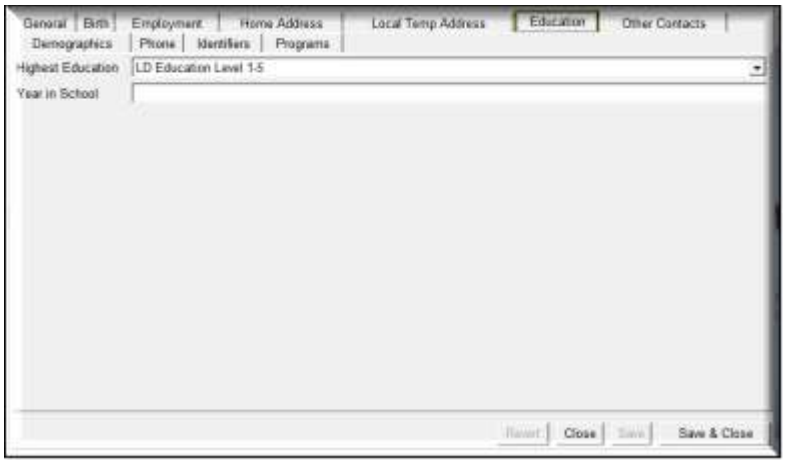



## Local Temp Address Tab

The **Local Temp Address** tab holds the patient's temporary address information if they live a distance from the center and are temporarily staying at a local residence.




## Education Tab

The **Education** tab holds the patient's highest level of education and/or year in school.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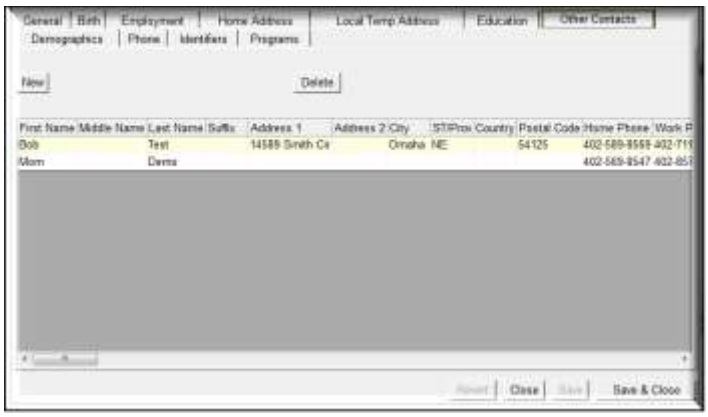
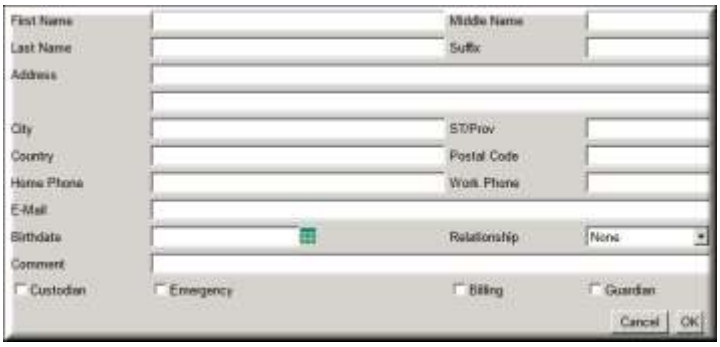
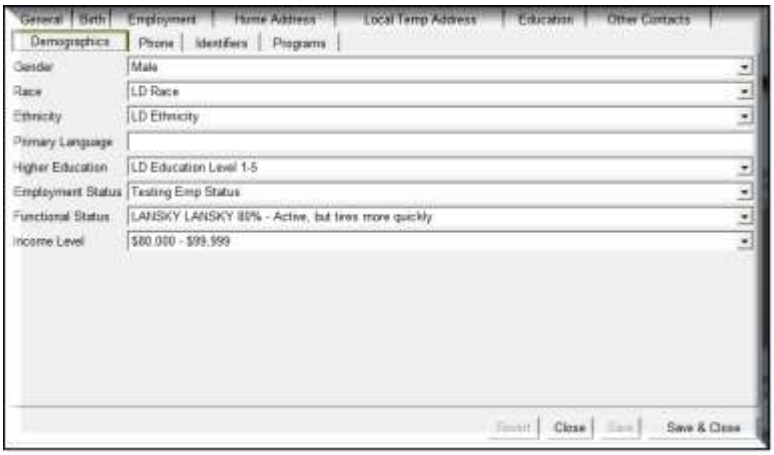



## Other Contacts Tab

The **Other Contacts** tab holds the information for the patient's other contacts such as emergency, custodial, billing, etc. If you need to add to the contacts area, select the new button and it will open a window for you to enter this information. To remove a contact, highlight the contact row and click the **Delete** button. *For the patient's emergency contact, be sure that the Emergency contact box is checked.




## Demographics Tab

The **Demographics** tab holds information such as gender, race, ethnicity and the patient's functional status. The education and employment fields will auto-populate with previously entered information.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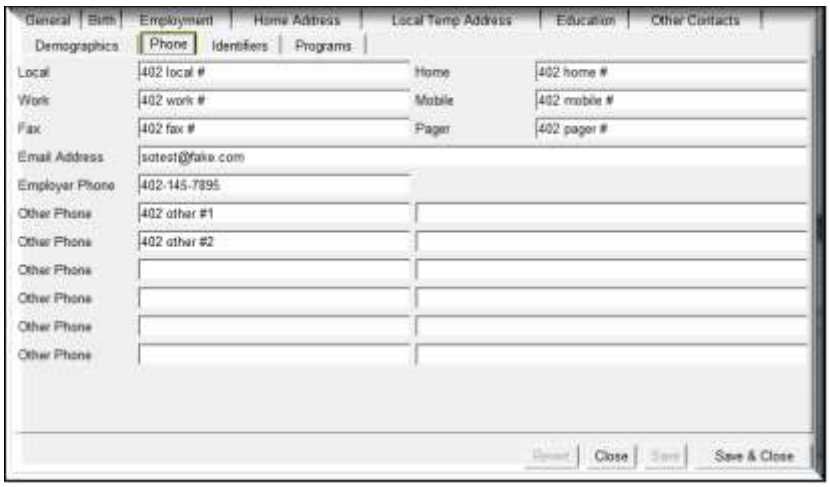
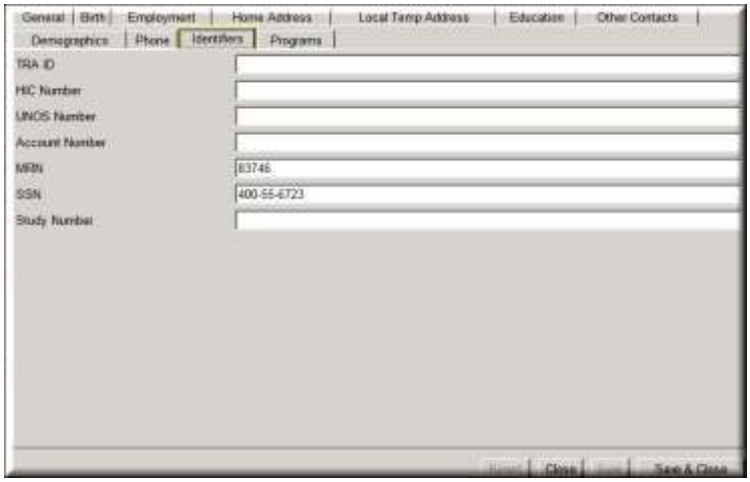



## Phone Tab

The **Phone** tab holds the contact information for the patient. Information can be entered via free text.




## Identifiers Tab

The **Identifiers** tab holds the external identifiers for the patient such as SSN, MRN, UNOS Number, etc. Your site may have other fields corresponding to your specific site identifiers.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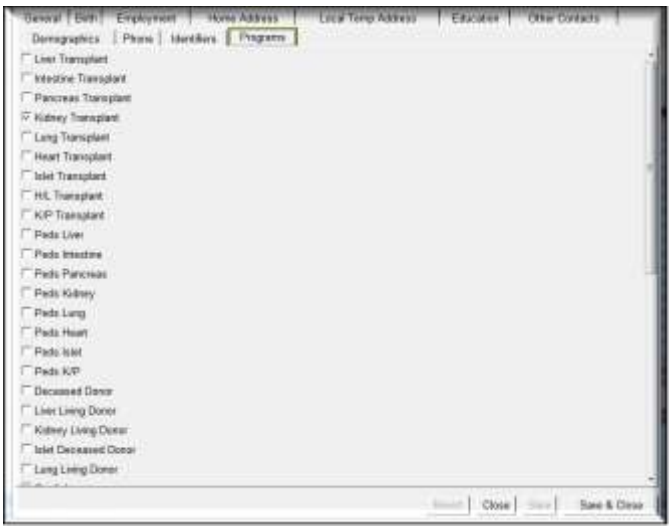


## Programs Tab

The **Programs** tab holds the program(s) that the patient has been assigned to. It's important to assign the patient to a program. If not assigned, they'll fall on the unassigned list and won't come up in a general search when trying to find the patient.


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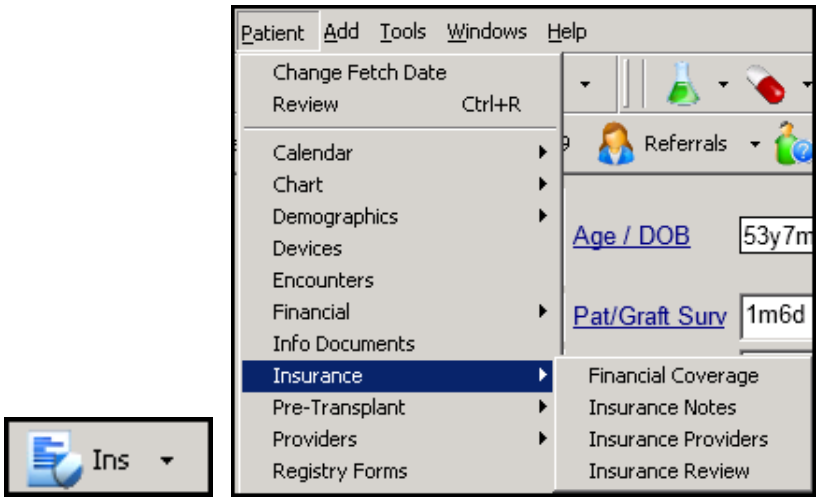
# Insurance

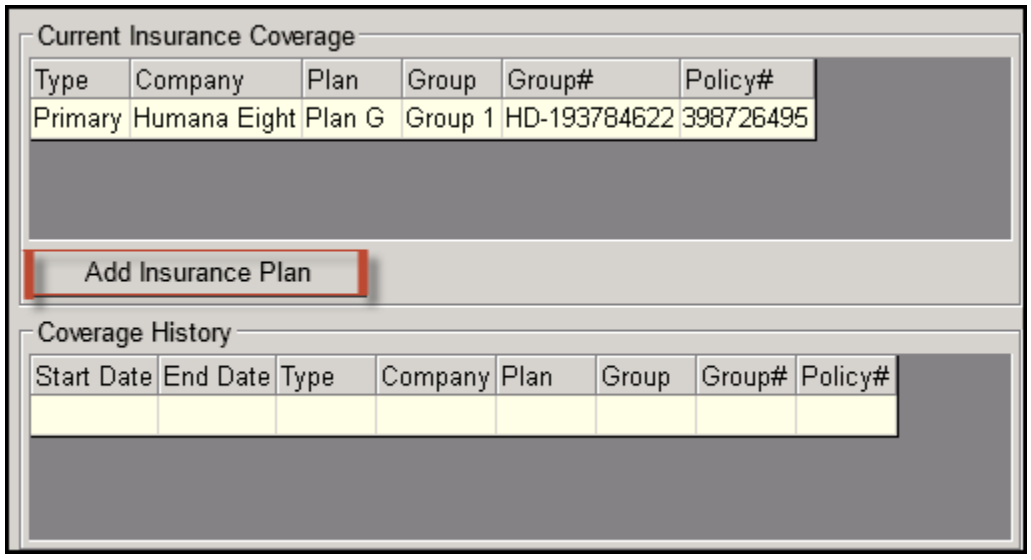
Insurance can be added at the time of referral or can be added to the patient record at a later time.

## Adding Insurance Providers

Insurance can be added to the patient record using **Insurance** icon or from the **Patient** Master Menu, select Insurance, then **Insurance Providers**.




The insurance window opens displaying current insurance coverage at the top and historical insurance at the bottom.




Click the **Add Insurance Plan** button to add a new insurance provider to the patient record.
Once an insurance has been set to Inactive it will display in the Coverage History.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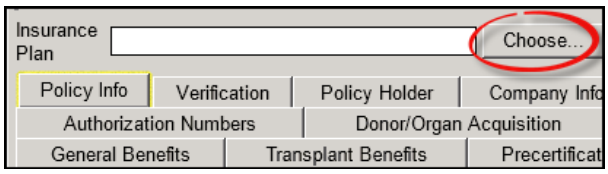
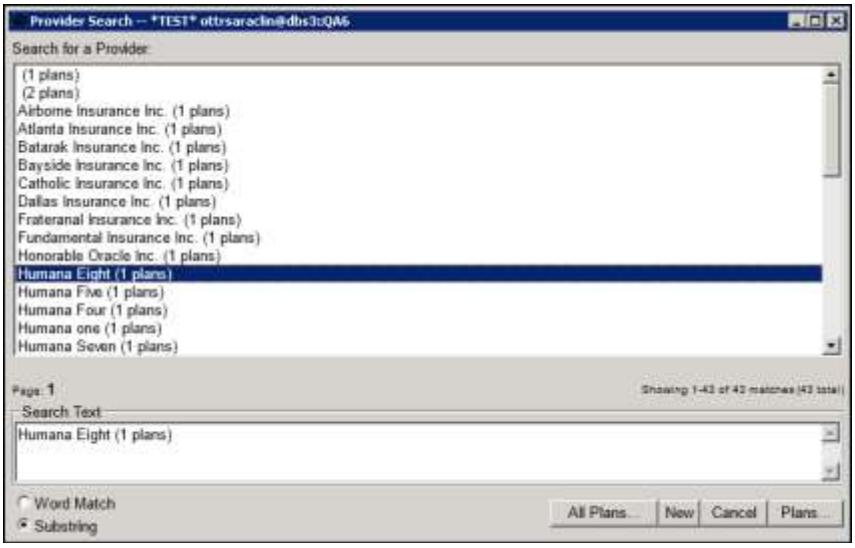



Click the **Choose** button to select an insurance provider.




Begin typing the insurance provider's name in the **Search Text** field to limit the displayed options. Once the desired insurance provider is displayed, double click on it. Notice that the number of plans for that provider is displayed in parentheses.

The various plans for this insurance provider are displayed for the user to select from. Double click on the desired plan or highlight and click **OK**.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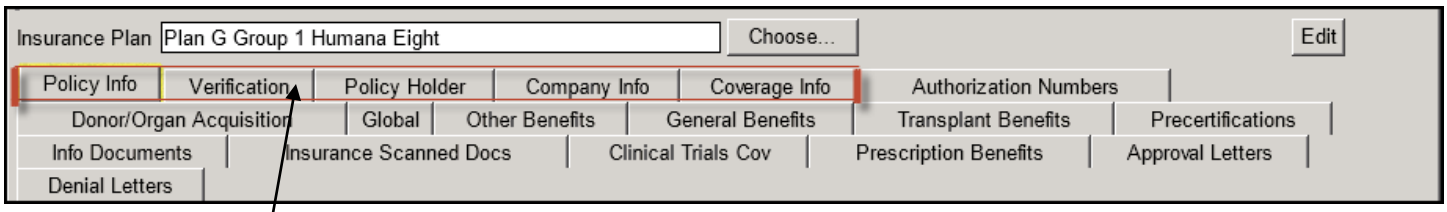


## Standard Insurance Tabs

The standard insurance area of OTTR™ will come with certain standard tabs. There are 8 additional tabs that are part of the Financial Module if purchased: Authorization Information, Evaluation Precertification, Transplant Approval, Donor Coverage, Organ Acquisition, HLA Coverage, General Benefits, Global Information, Prescription Benefits, and Transplant Benefits.
The Standard Tabs will be reviewed here and you will be provided additional documentation if the Financial Module is purchased.

### Policy Info Tab

This tab provides information which the financial coordinator will need when contacting the insurance provider. During the initial insurance verification process they will complete this tab for future reference.
**Insurance Type -** Use the dropdown to select primary, secondary, self pay, inactive, etc

**Policy # -** Free text the policy number

**Group # -** Free text the group number

**Drug Benefit Plan -** Free text the name of the drug benefit plan and plan number if desired

**Case Manager -** Free text the name of the name and contact information in the applicable fields

**Additional Case Manager Info -** Use these fields to add additional information related to the case manager


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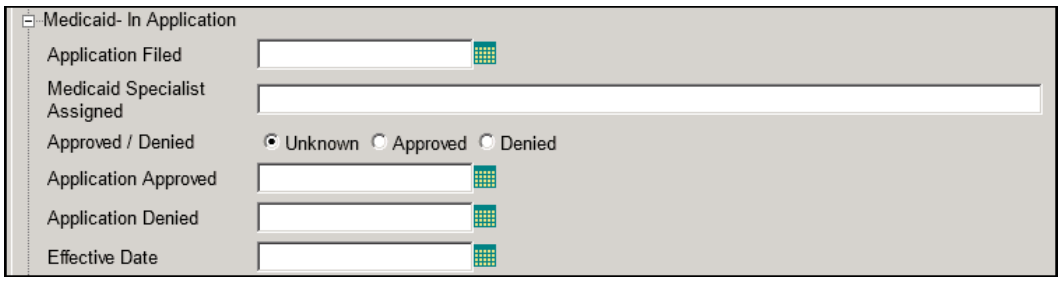
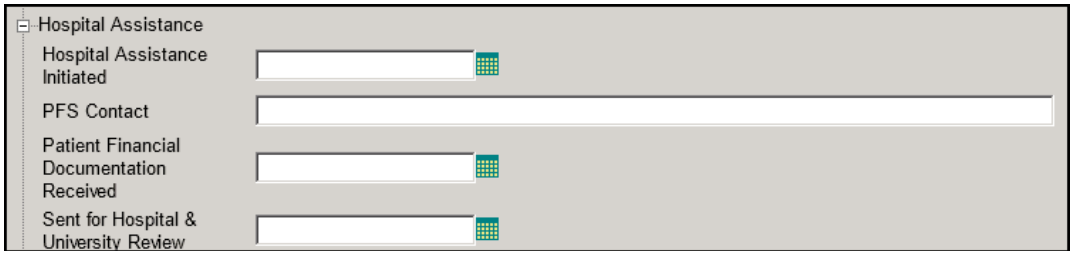
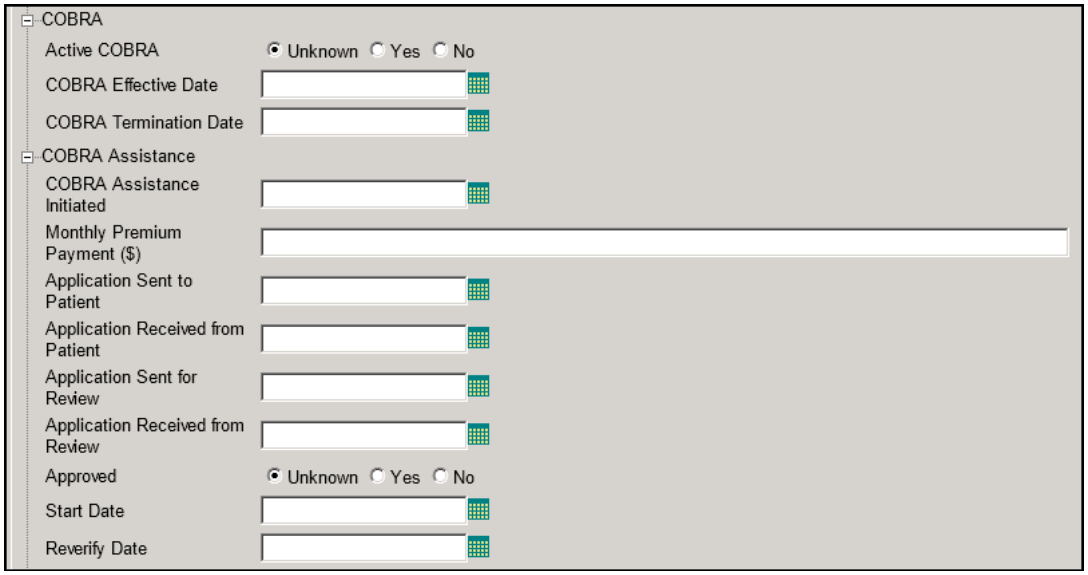



Medicaid Information can be entered.




Hospital Assistance and patient financial services information can be entered.




COBRA information can be documented

Medicare date can be entered if applicable.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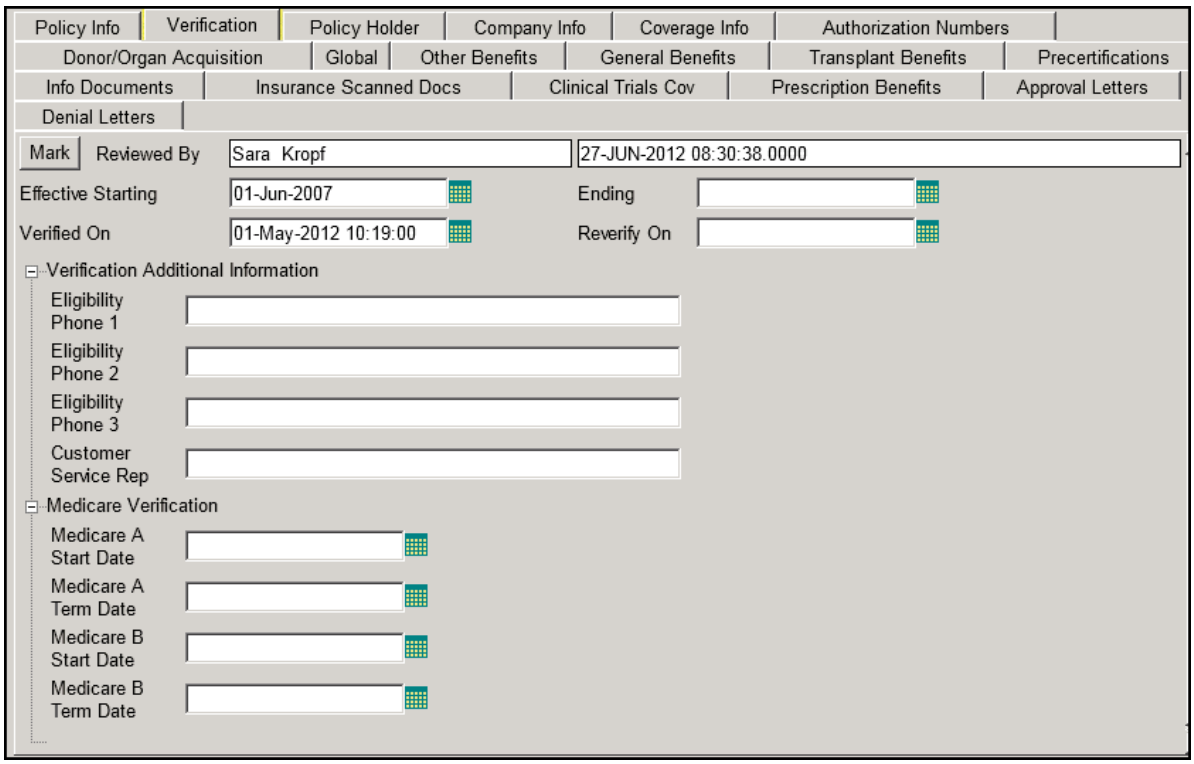
## Verification Tab




**Effective Starting -** Enter the date that the insurance coverage started.

**Until -** If coverage is known to end on a particular date, the date that it becomes ineffective.

**Verified On -** Enter the date that the insurance coverage is verified.

**Reverify On -** Enter the date that the insurance is due for re-verification.

**Medicare Verification** dates can be entered.

The patient will populate the **Financial Pending Benefits Verification** list until the **Effective Starting** and **Verified On** dates have been entered. They will fall off the list once the dates have been entered.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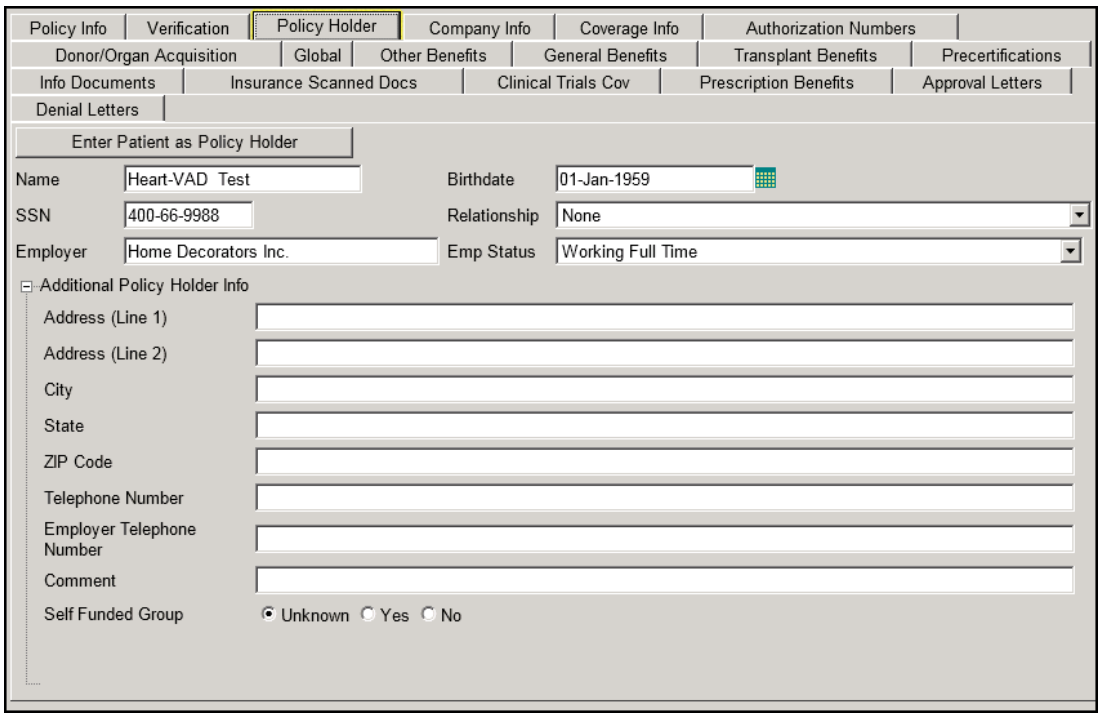
## Policy Holder Tab




If the patient is the policy holder click on the **Enter Patient as Policy Holder** button to auto populate the remaining fields. If the patient is not the policy holder enter the policy holder's information.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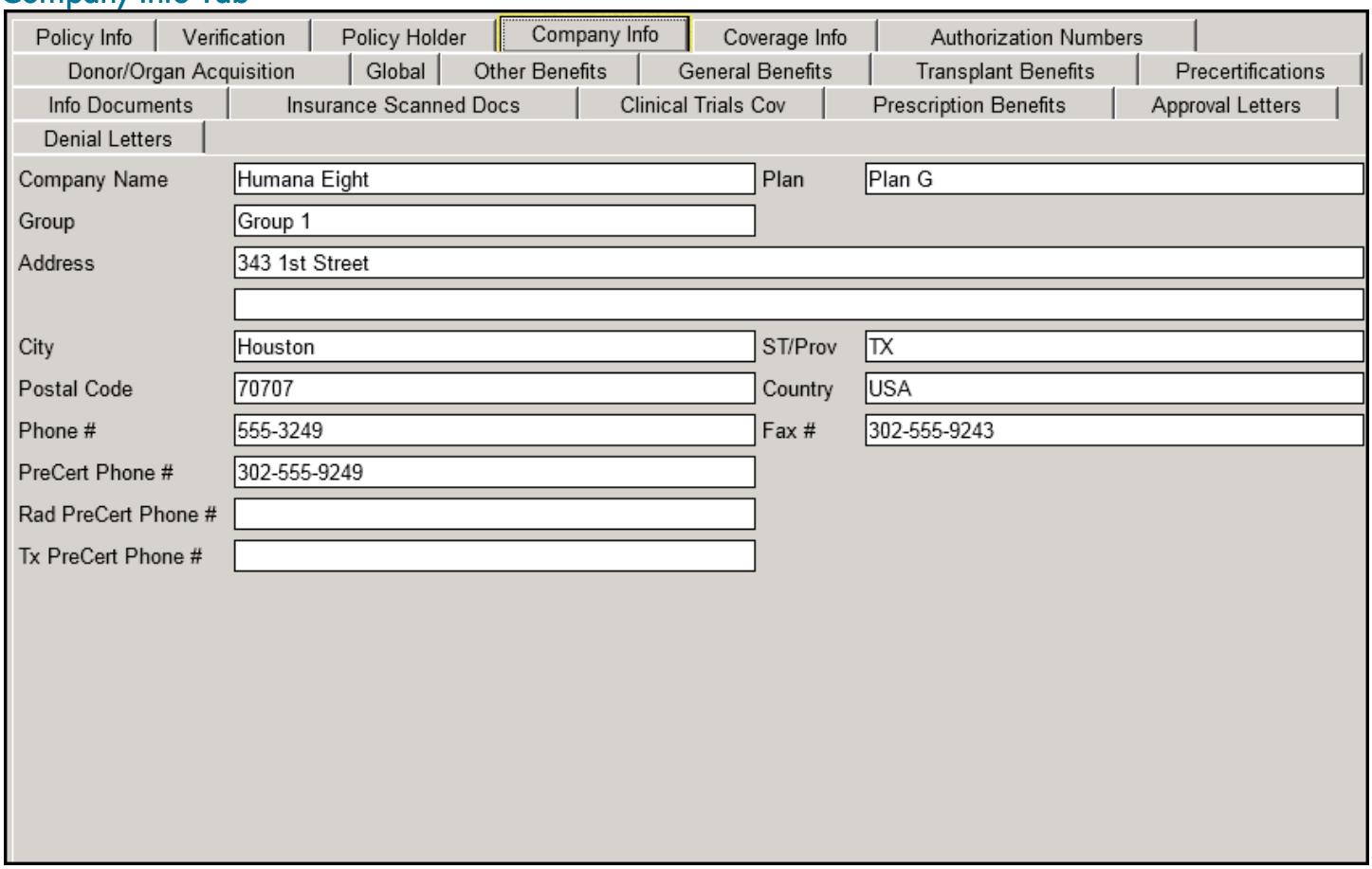
## Company Info Tab




This tab is auto-populated by the information added when the insurance provider was entered into the database.
If information displayed here needs to be updated click on the **Edit** button in the upper right portion of this window.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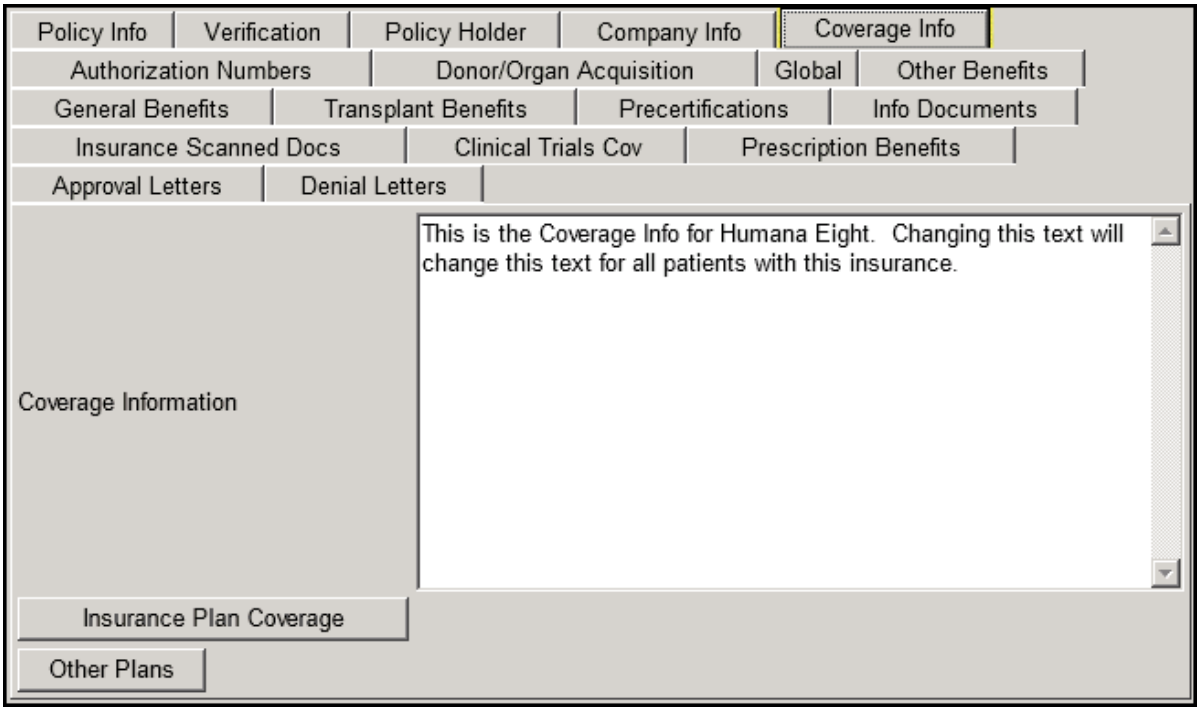
## Coverage Info Tab




To enter additional Coverage Information which is global in nature, click on the **Edit** button and then click on the **Coverage** tab to enter the global information. Notes should be signed and dated.
**Note:** Changes made here will change the information for all patients with this insurance plan.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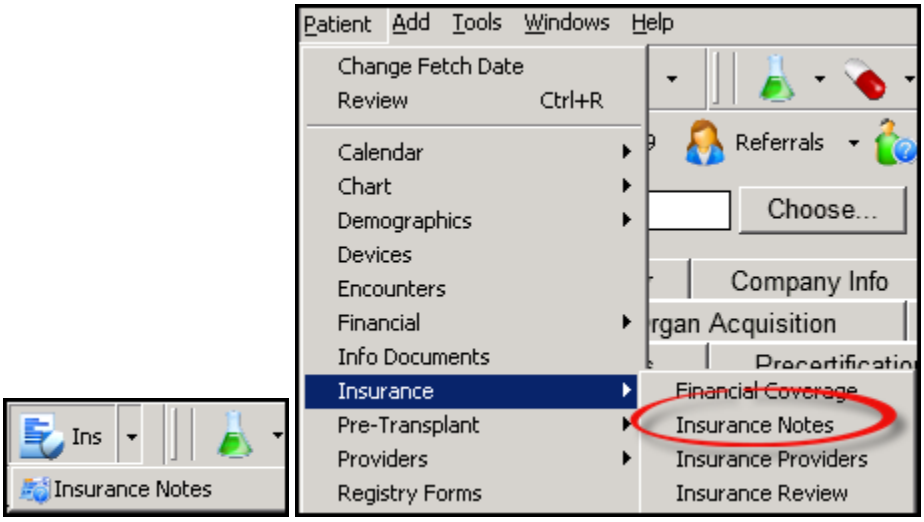
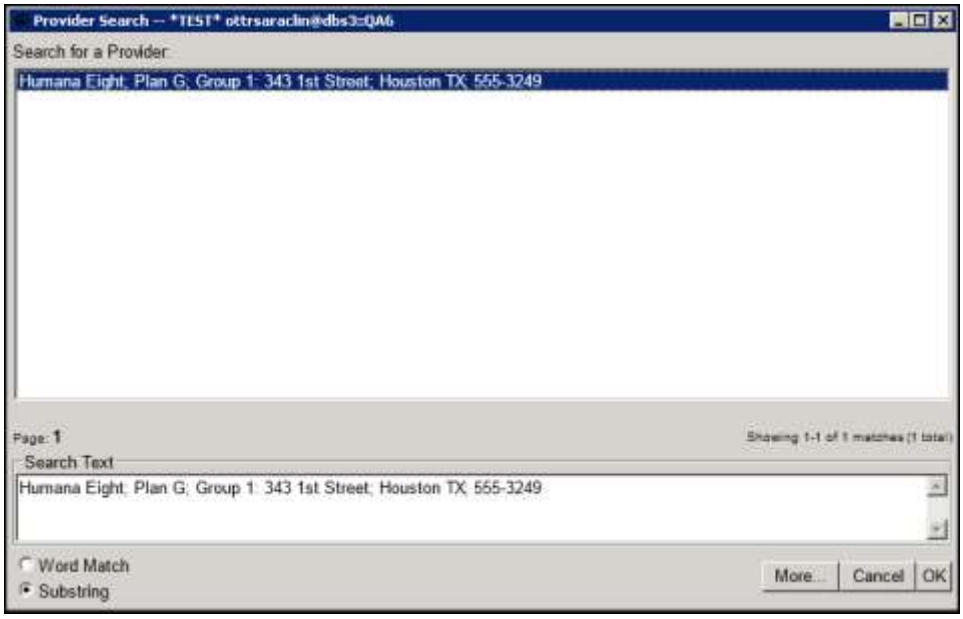
# Insurance Notes

An insurance note can be added using the Insurance Notes Icon, or from the **Patient** Master Menu, select **Insurance**, then **Insurance Notes**.




**Insurance Plan -** Click the **Change** button to select the patient's associated insurance provider you wish to make a note about.




If multiple insurance providers have been associated to the patient's record, select the plan you wish to write the note on.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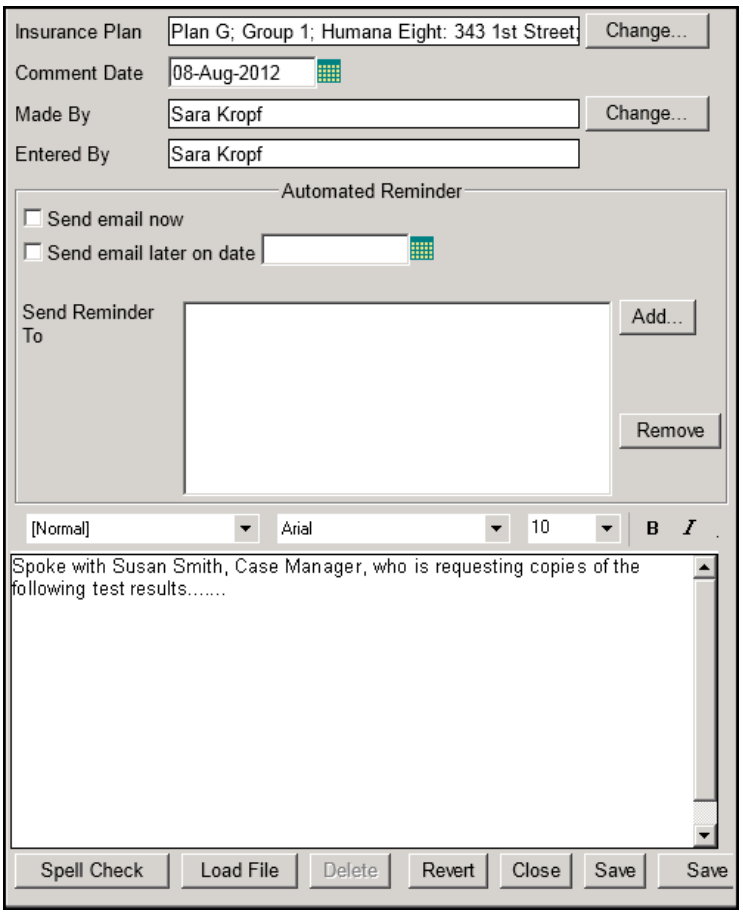


**Comment Date -** Defaults to today's date, use the green calendar to change the date or type in the date.

**Made By -** Displays the name of the person logged in and adding the note.

**Entered By -** Displays the name of the person logged in and entering the note.

**Send email now -** Place a check in the box to send the email now.

**Send email later on date -** Place a check in the box to send the email at a later date.

**Send Reminder To -** Use the **Add** button to add the person you want to send the note to.

**Load File** - Select to attach a document or file to the note.

**Save and Close** after typing in the note.


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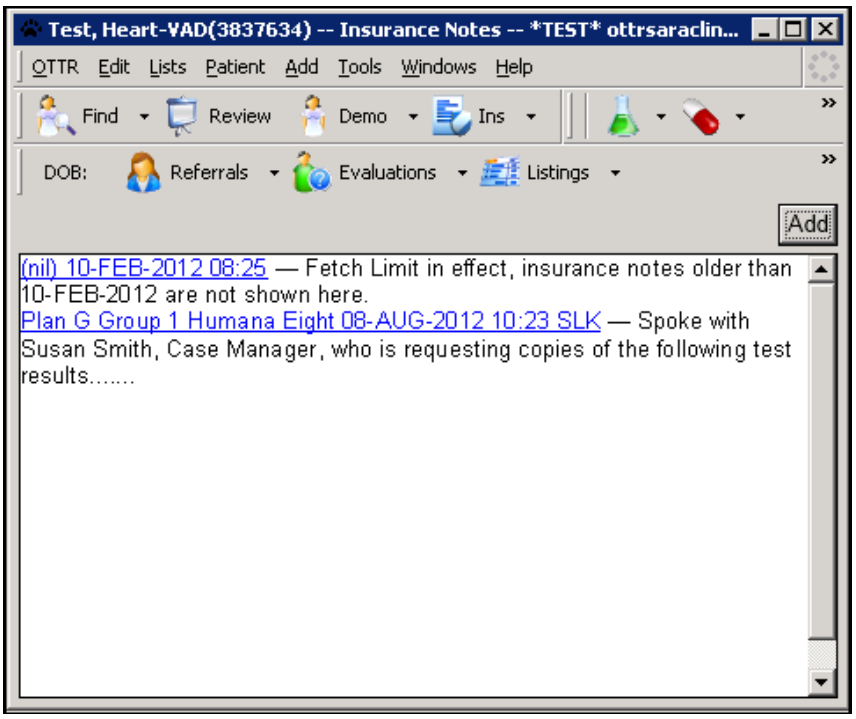
Test, Heart-VAD(3837634) -- Insurance Notes -- *TEST* ottrsaraclin...
OTTR Edit Lists Patient Add Tools Windows Help
Find Review Demo Ins
DOB: Referrals Evaluations Listings
Add
(nil) 10-FEB-2012 08:25 — Fetch Limit in effect, insurance notes older than 10-FEB-2012 are not shown here.
Plan G Group 1 Humana Eight 08-AUG-2012 10:23 SLK — Spoke with Susan Smith, Case Manager, who is requesting copies of the following test results.....

The financial coordinator may document each time they have called and or have spoken with an insurance provider. They may update where they are in the patient's insurance process so that clinicians will be able to quickly review the status.


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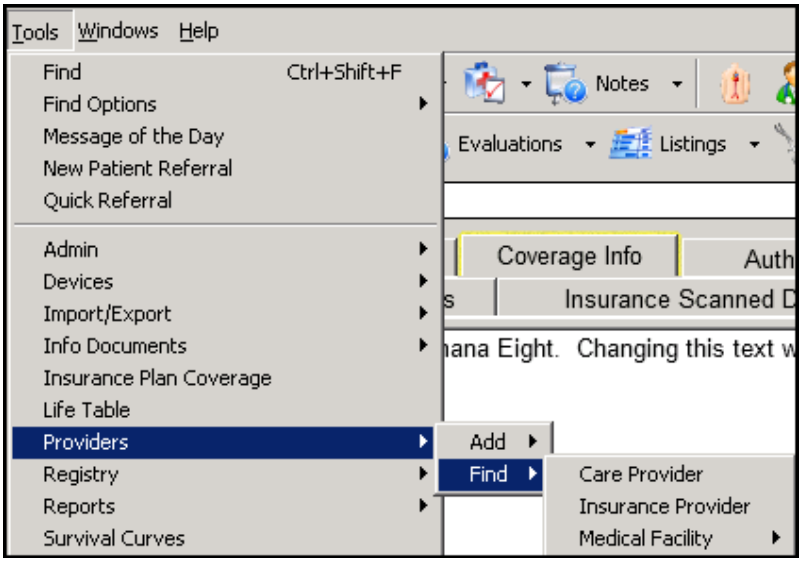
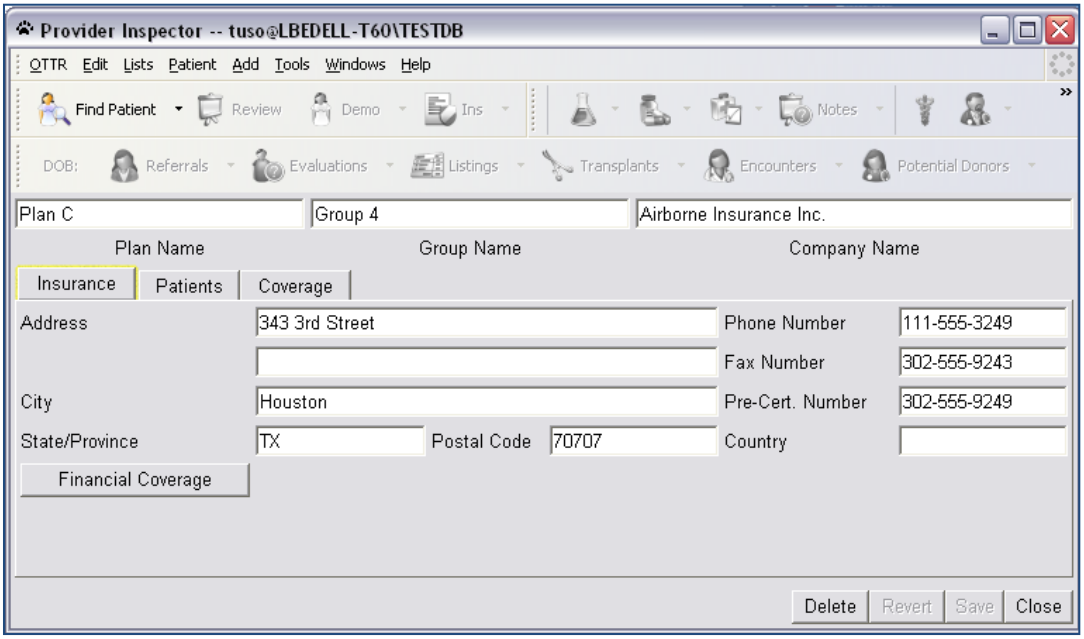
# Adding an Insurance Provider to the Database

Prior to adding a new insurance provider to the database, you should perform a search ensuring that the provider isn't already present in the system.




From the **Tools** Master Menu, select **Providers,** select **Find,** then **Insurance Provider**. If the provider isn't present, add them from the **Tools** Master Menu, selecting **Providers,** then Add, then **Insurance Provider**.

## Insurance Tab




**Company Name** – Enter the insurance provider's company name. This is what displays when performing a search.

**Group Name** – Enter the provider's group name.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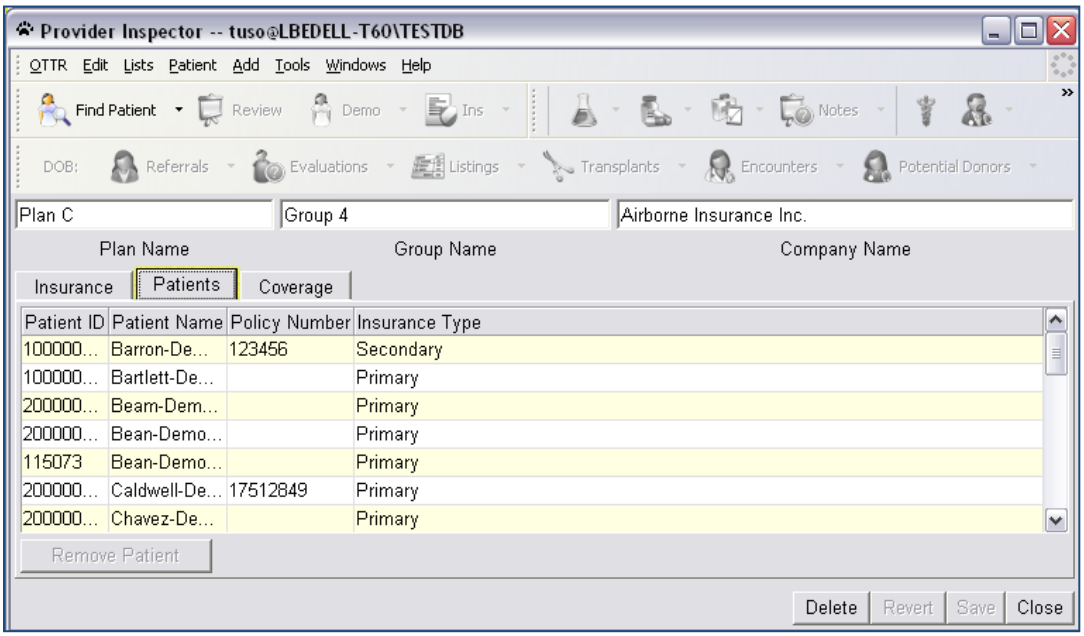
**Plan Name** – Enter the provider's plan name.

**Address** – Enter the provider's physical address, phone, fax and per-cert phone number.

**Contact Phone Numbers** – Enter the appropriate phone numbers in the fields provided.

## Patients Tab




Initially, you won't see any patients listed under this tab for the new insurance provider you've just created. This tab displays all patients who've had this insurance plan attached to their record.

## Coverage Tab

Provider Inspector -- tuso@LBEDELL-T60\TESTDB
Plan C
Group 4
Airborne Insurance Inc.
Plan Name
Group Name
Company Name
Insurance Patients Coverage
This is the Coverage Info for Airborne Insurance Inc... Changing this text will change this text for all patients with this insurance.
Delete Close

Information here will display for all patients with this insurance provider, plan and group. Financial coordinators may write notes which apply to all patients with this insurance coverage. An example may be information about specific tests which require pre authorizations.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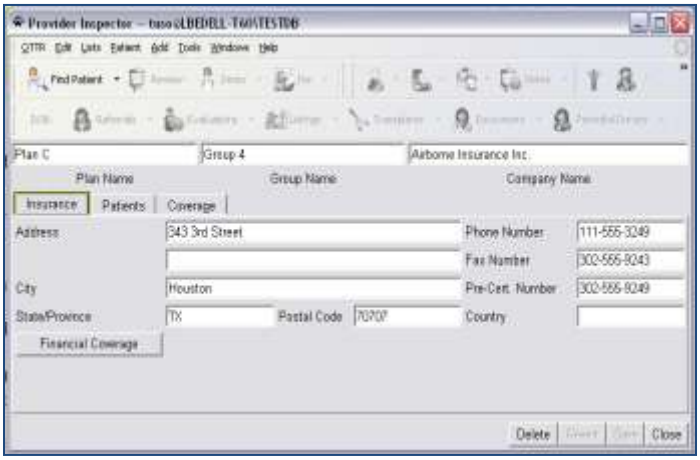
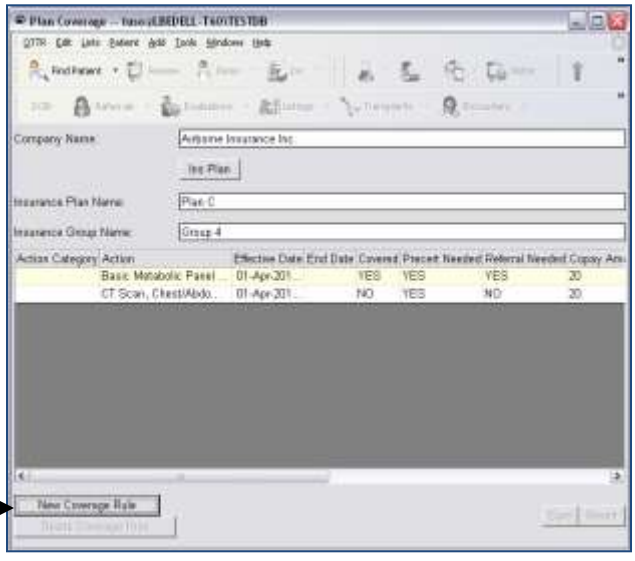
# Financial Coverage Rules

If desired, financial coverage rules may be built for an insurance provider which defines what actions require pre-authorization. When an action is ordered for a patient which has a financial coverage defined, a message box will appear stating that pre authorization is required upon saving the action. The action will fall onto the **Financial Actions Needing Pre-Auth with patient, plan and type** list. The financial coordinator will obtain the required authorization prior to the action being scheduled for the patient.




In the **Insurance** tab, select the button.






New Coverage Rule

All existing coverage rules will display for this plan. To add a new rule, select the **New Coverage Rule** button.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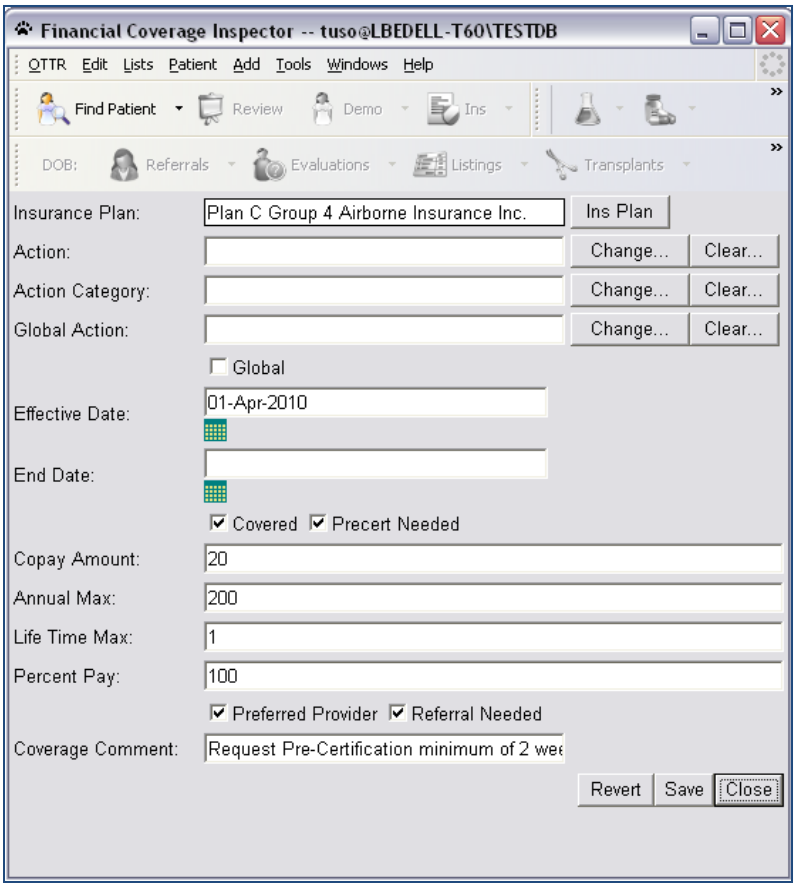


Select the type of coverage rule you wish to create using the **Change** button next to the Action, Action Category and Global Action Fields. A window will then open for you to choose the appropriate entry.

**Effective** and **End Dates** can be entered if applicable.

**Covered -** Place a check in the box if the item is covered by the insurance plan.

**Precert Needed -** Place a check in the box if the item requires precertification.

**Copay Amount, Annual Max, Life Time Max,** and **Percent Pay** can be entered if applicable.

**Preferred Provider** and **Referral Needed** can be checked if requirements for that particular coverage rule.

**Coverage Comment -** Additional comments can be documented here.

**Save** and **Close** when finished.


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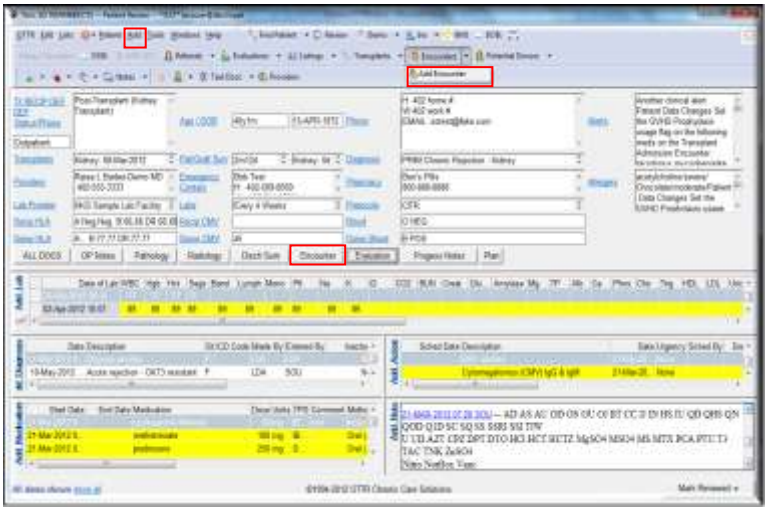
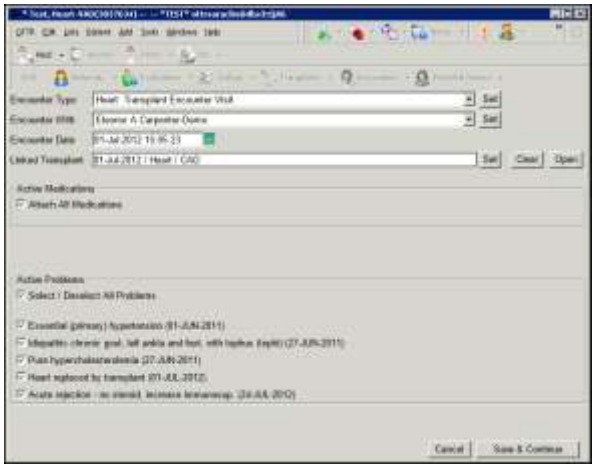
# Encounters

This section reviews the standard encounter record as well as how to add or access an existing encounter. Encounters represent visits that you've had with the patient, either by telephone or in the clinic. It's a detailed multi-tabbed entry form that is designed to replace paper charting. There are several ways of adding an Encounter to a patient's record.

- Add Master Menu and select Encounter
- The Encounters icon drop-down arrow
- The Encounter button on the Patient Review window



Once you've added the Encounter, the new Encounter window will open.



Click on the **Set** button for the **Encounter Type** field to search for the type of encounter you wish to add.

Click the **Set** button for the **Encounter With** field to enter the provider who is seeing the patient during the visit.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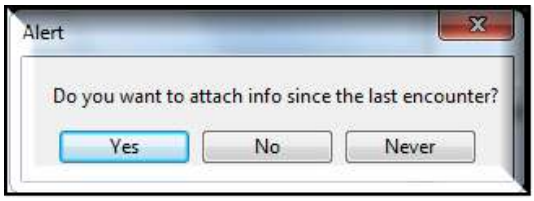
The **Encounter Date** will auto-populate with today's date and time, you can adjust if needed.

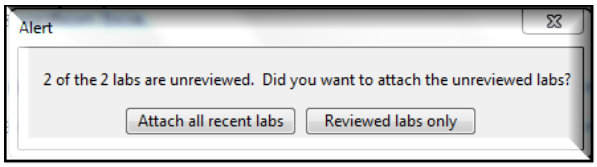
If the patient is post transplant, you can link the encounter to the appropriate transplant using the **Set** button next to the **Linked Transplant** field.

**Active Medications:** Active medications may be attached to the encounter. You have the ability to review this information with the patient and mark the medications as having been verified during this clinic visit. To attach active medications place a checkmark in the **Attach All Medications** option box.

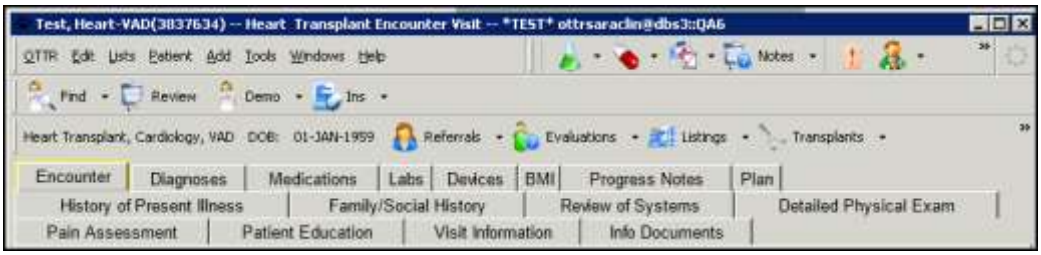
**Active Problems:** Notice the **Active Problems** frame area. If active problems have been entered for the patient they will display here. These problems may be selected to be included within the new encounter under the **Diagnoses** tab. Click on the **Save & Continue** button.




You'll be prompted with an alert box to attach the patient's information since the last Encounter. You can select Yes, No or Never based on the information you would like to have pulled into this Encounter. If you select Yes, items such as labs, that have entered the system since the last encounter will be attached.




You'll also get another alert telling you the number of unreviewed labs. You can opt to **Attach all recent labs**, or just **Reviewed labs only**. Once you've addressed the alert messages, the Encounter window will appear. You'll see several tabs in each Encounter that will vary based on the type of Encounter selected. There are tabs that will accompany each encounter. Some tabs may be different depending on the type of encounter selected. We'll cover the common tabs below.





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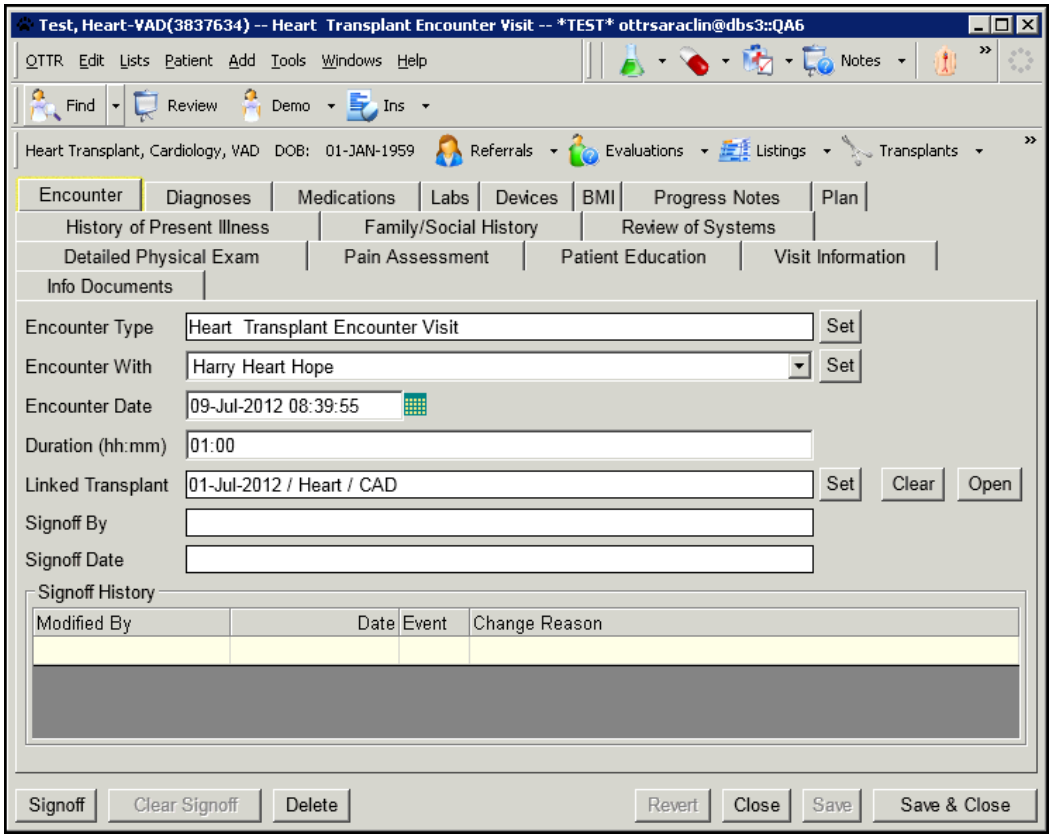
# Encounter Tab


Test, Heart-VAD(3837634) -- Heart Transplant Encounter Visit -- *TEST* ottrsaraclin@dbs3::QA6
OTTR Edit Lists Patient Add Tools Windows Help
Notes
Find Review Demo Ins
Heart Transplant, Cardiology, VAD DOB: 01-JAN-1959
Referrals Evaluations Listings Transplants
Encounter Diagnoses Medications Labs Devices BMI Progress Notes Plan
History of Present Illness Family/Social History Review of Systems
Detailed Physical Exam Pain Assessment Patient Education Visit Information
Info Documents
Encounter Type Heart Transplant Encounter Visit Set
Encounter With Harry Heart Hope Set
Encounter Date 09-Jul-2012 08:39:55
Duration (hh:mm) 01:00
Linked Transplant 01-Jul-2012 / Heart / CAD Set Clear Open
Signoff By
Signoff Date
Signoff History
Modified By Date Event Change Reason
Signoff Clear Signoff Delete Revert Close Save Save & Close

**Encounter Type:** Displays the encounter type added. To change this encounter type, select the Set button.

**Encounter With:** Displays the care provider's name that the patient is seeing. To change name of the care provider, select the Set button.

**Encounter Date:** Displays the date and time the encounter was added. This can be modified using the green calendar button.

**Duration (hh mm):** Sites may track how long encounters take. Enter the total time of visit.

**Linked Transplant:** Displays the transplant it is linked to if post transplant. To link it to a different transplant, click on the Set button to select the transplant event.

**Signoff By/Date:** To signoff an encounter you must have the permissions granted in OTTR™. Select the Signoff button. To remove a signoff, select the Clear Signoff button. Once an encounter is signed off, it is locked and no further documentation can be added or modified.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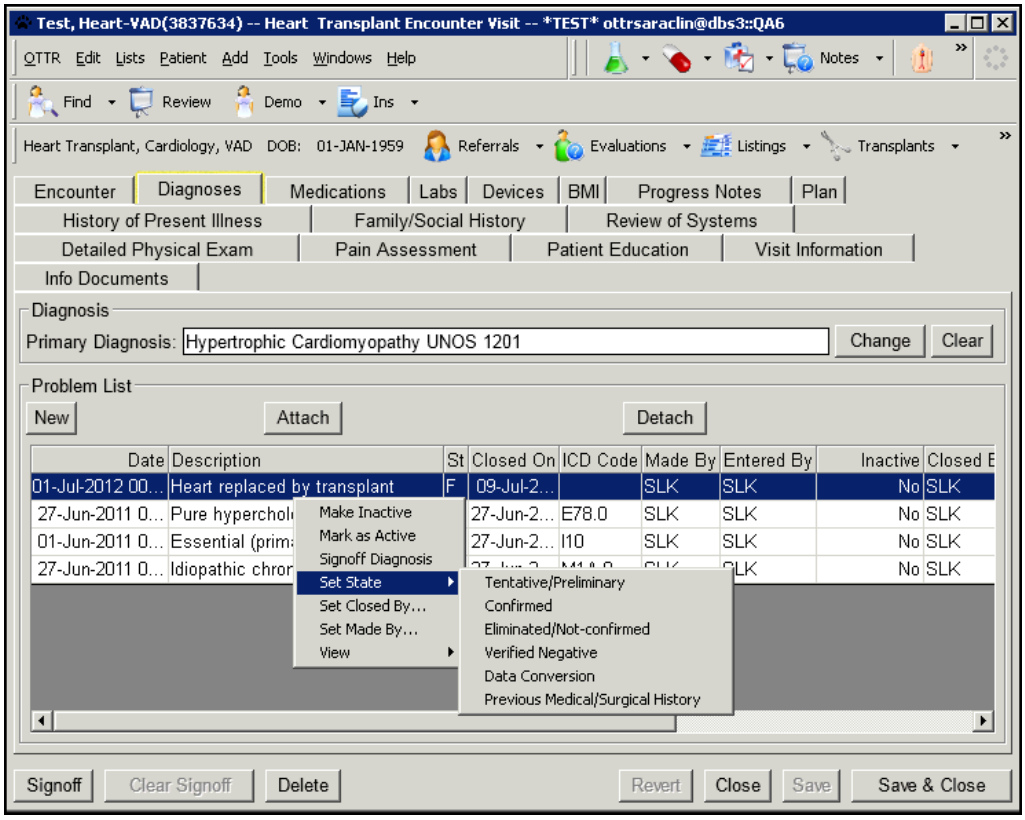
# Diagnosis Tab


Test, Heart-VAD(3837634) -- Heart Transplant Encounter Visit -- *TEST* ottrsaraclin@dbs3::QA6
OTTR Edit Lists Patient Add Tools Windows Help
Notes
Find Review Demo Ins
Heart Transplant, Cardiology, VAD DOB: 01-JAN-1959
Referrals Evaluations Listings Transplants
Encounter Diagnoses Medications Labs Devices BMI Progress Notes Plan
History of Present Illness Family/Social History Review of Systems
Detailed Physical Exam Pain Assessment Patient Education Visit Information
Info Documents
Diagnosis
Primary Diagnosis: Hypertrophic Cardiomyopathy UNOS 1201
Change Clear
Problem List
New Attach Detach
Date Description St Closed On ICD Code Made By Entered By Inactive Closed E
01-Jul-2012 00... Heart replaced by transplant F 09-Jul-2... SLK SLK No SLK
27-Jun-2011 0... Pure hypercholi 27-Jun-2... E78.0 SLK SLK No SLK
01-Jun-2011 0... Essential (prim 27-Jun-2... I10 SLK SLK No SLK
27-Jun-2011 0... Idiopathic chror SLK No SLK
Make Inactive
Mark as Active
Signoff Diagnosis
Set State
Set Closed By...
Set Made By...
View
Tentative/Preliminary
Confirmed
Eliminated/Not-confirmed
Verified Negative
Data Conversion
Previous Medical/Surgical History
Signoff Clear Signoff Delete Revert Close Save Save & Close

**Primary Diagnosis:** Displays the patient's primary diagnosis, or reason for transplant, assigned in the General Medical window.

**Problem List:** Diagnoses can be viewed, have the state changed, and made inactive using the right click functionality if appropriate. Clinicians have the ability to enter new problems or diagnoses, or to attach and detach existing problems. The **Shift** button can be used to highlight multiple diagnoses to manage, whereas the **Control** button can be used to highlight intermittent diagnoses to manage. **Note**: this same principle applies in the labs and medications tabs as well.

To enter a new problem, click the **New** button.

**Note:** refer to the *Diagnosis* section for detailed instructions on adding and managing diagnoses.

If you didn't attach the problem(s) when adding the encounter, you can click the **Attach** button to add a diagnosis to the encounter. Likewise, if you've attached a diagnosis that doesn't apply to this encounter or no longer active, you can **Detach** it from the encounter. **Note:** this same functionality occurs in the labs, medications, progress notes, and plan tabs as well. When deciding whether to Attach or Detach items, think about printing the encounter to send to a referring physician as an update, and whether that information should be included or not. Also remember that the information will still be present in the patient record, it just won't show up in that particular encounter.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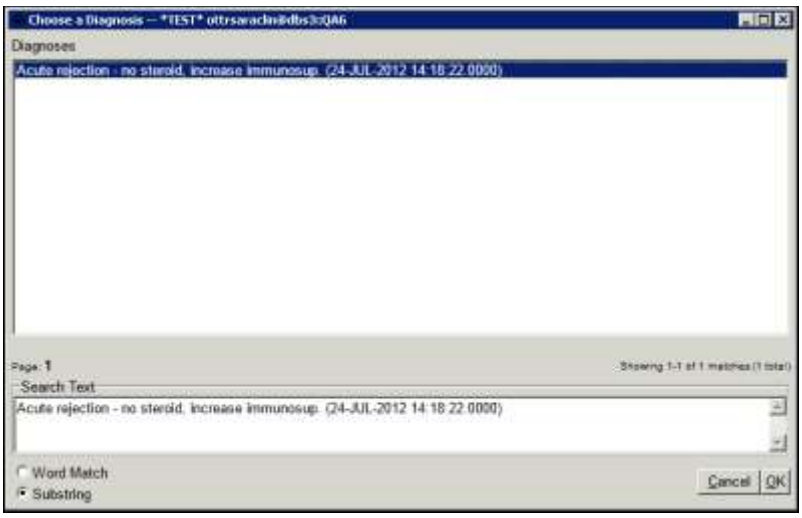
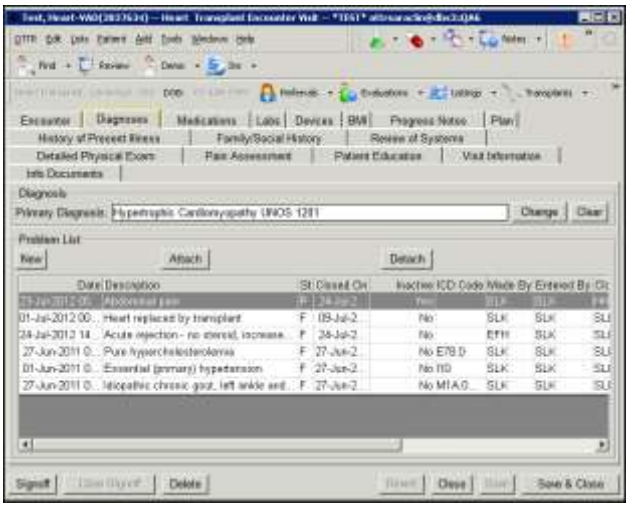
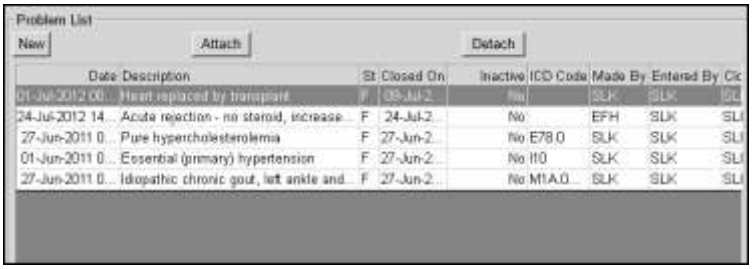



Click the **Attach** button to add an unattached diagnoses. All unattached diagnoses will display, highlight the diagnosis and select **OK**, or double click to add the diagnosis.




To Detach a diagnosis or problem that isn't relative to the encounter, highlight the problem row and click **Detach**. The problem will be removed from the encounter. Notice how the 'abdominal pain' diagnosis has been detached below.


Problem List
New
Attach
Detach
Date Description
St
Closed On
Inactive
ICD Code
Made By
Entered By
01-Jul-2012 00... Heart replaced by transplant F 09-Jul-2... No SLK SLK
24-Jul-2012 14... Acute rejection - no steroid, increase... F 24-Jul-2... No EFH SLK
27-Jun-2011 0... Pure hypercholesterolemia F 27-Jun-2... No E78.0 SLK SLK
01-Jun-2011 0... Essential (primary) hypertension F 27-Jun-2... No I10 SLK SLK
27-Jun-2011 0... Idiopathic chronic gout, left ankle and... F 27-Jun-2... No M1A.0... SLK SLK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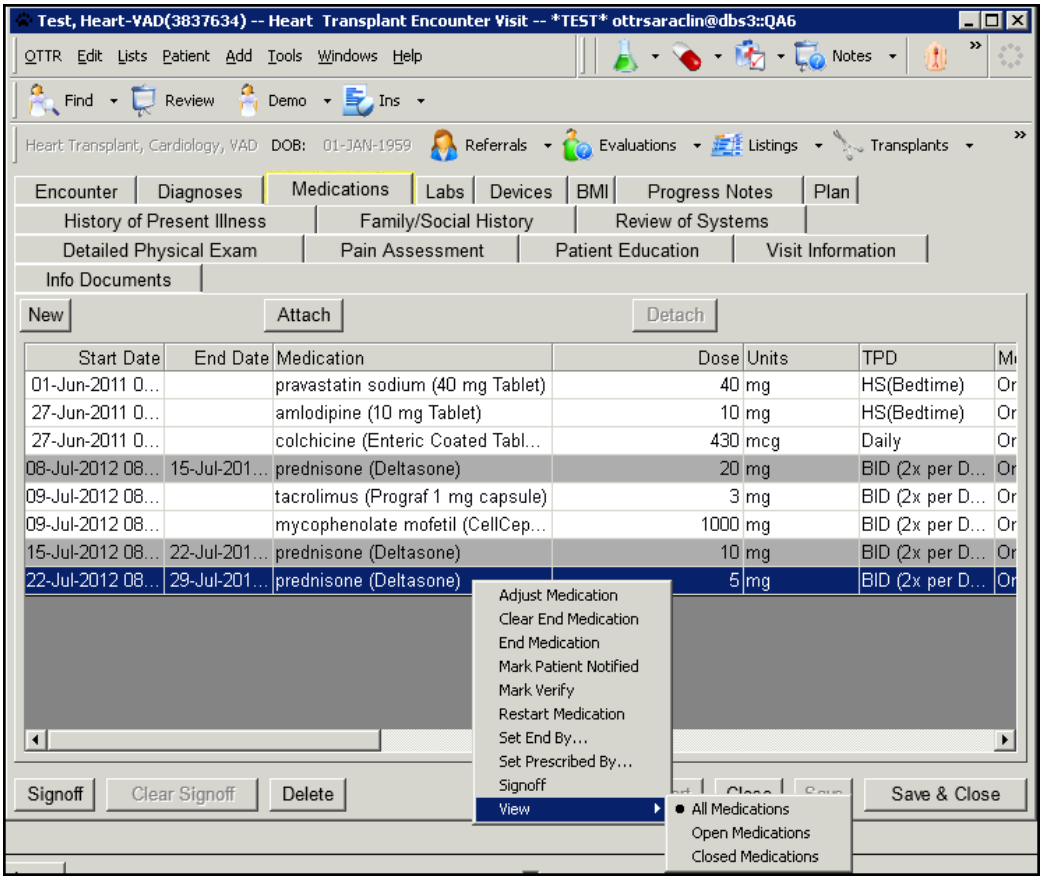
# Medications Tab


Test, Heart-VAD(3837634) -- Heart Transplant Encounter Visit -- *TEST* ottrsaraclin@dbs3::QA6
OTTR Edit Lists Patient Add Tools Windows Help
Notes
Find Review Demo Ins
Heart Transplant, Cardiology, VAD DOB: 01-JAN-1959 Referrals Evaluations Listings Transplants
Encounter Diagnoses Medications Labs Devices BMI Progress Notes Plan
History of Present Illness Family/Social History Review of Systems
Detailed Physical Exam Pain Assessment Patient Education Visit Information
Info Documents
New Attach Detach
Start Date End Date Medication Dose Units TPD
01-Jun-2011 0... pravastatin sodium (40 mg Tablet) 40 mg HS(Bedtime)
27-Jun-2011 0... amlodipine (10 mg Tablet) 10 mg HS(Bedtime)
27-Jun-2011 0... colchicine (Enteric Coated Tabl... 430 mcg Daily
08-Jul-2012 08... 15-Jul-201... prednisone (Deltasone) 20 mg BID (2x per D...
09-Jul-2012 08... tacrolimus (Prograf 1 mg capsule) 3 mg BID (2x per D...
09-Jul-2012 08... mycophenolate mofetil (CellCep... 1000 mg BID (2x per D...
15-Jul-2012 08... 22-Jul-201... prednisone (Deltasone) 10 mg BID (2x per D...
22-Jul-2012 08... 29-Jul-201... prednisone (Deltasone) 5 mg BID (2x per D...
Adjust Medication
Clear End Medication
End Medication
Mark Patient Notified
Mark Verify
Restart Medication
Set End By...
Set Prescribed By...
Signoff
View
All Medications
Open Medications
Closed Medications
Signoff Clear Signoff Delete Save & Close

The medication tab displays open medications which the patient is currently taking. In OTTR™ these are referred to as **Open Medications**. Medications that the patient is no longer taking are referred to as **Closed**. Medications can be managed using right click functionality as well.

**Note:** refer to the notes above under Diagnoses Tab for more functionality information.

To add a new medication, click on the **New** button. To add an existing medication to the encounter record, click on the **Attach** button. To remove a medication, highlight the desired medication and click the **Detach** button.

**Note:** refer to the *Medications* manual section for detailed information on adding and managing medications.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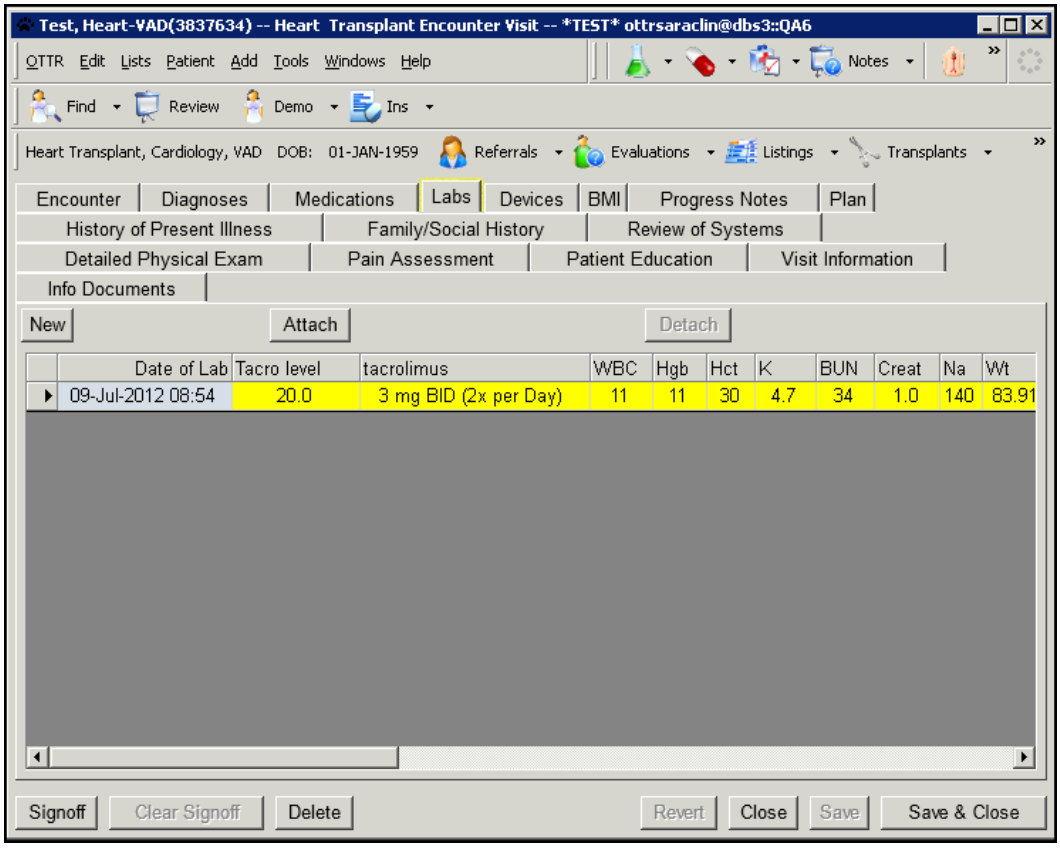
# Labs Tab


Test, Heart-¥AD(3837634) -- Heart Transplant Encounter ¥isit -- *TEST* ottrsaraclin@dbs3::QA6
OTTR Edit Lists Patient Add Tools Windows Help
Notes
Find Review Demo Ins
Heart Transplant, Cardiology, VAD DOB: 01-JAN-1959
Referrals Evaluations Listings Transplants
Encounter Diagnoses Medications Labs Devices BMI Progress Notes Plan
History of Present Illness Family/Social History Review of Systems
Detailed Physical Exam Pain Assessment Patient Education Visit Information
Info Documents
New Attach Detach
Date of Lab Tacro level tacrolimus WBC Hgb Hct K BUN Creat Na Wt
09-Jul-2012 08:54 20.0 3 mg BID (2x per Day) 11 11 30 4.7 34 1.0 140 83.91
Signoff Clear Signoff Delete Revert Close Save Save & Close

Lab results can enter the system in two ways, through an interface or via manual entry. Those results are then grouped together into flowsheets. The lab flowsheet will display different values depending on the transplant phase. In the example above, the patient is in the post-transplant phase and the flowsheet displays certain immunosuppressant drug level values along with the dose of immunosuppressant that the patient is currently taking. Note that the labs are display in yellow until they are marked as reviewed.

To manually enter a lab result, click the **New** button. To attach existing lab results to this record, click the **Attach** button. To remove a lab result from this view, highlight the desired row and click the **Detach** button.

**Note**: refer to the notes in the Diagnoses Tab section regarding Attach and Detach functionality, and to the *Labs* document for manual entry instructions.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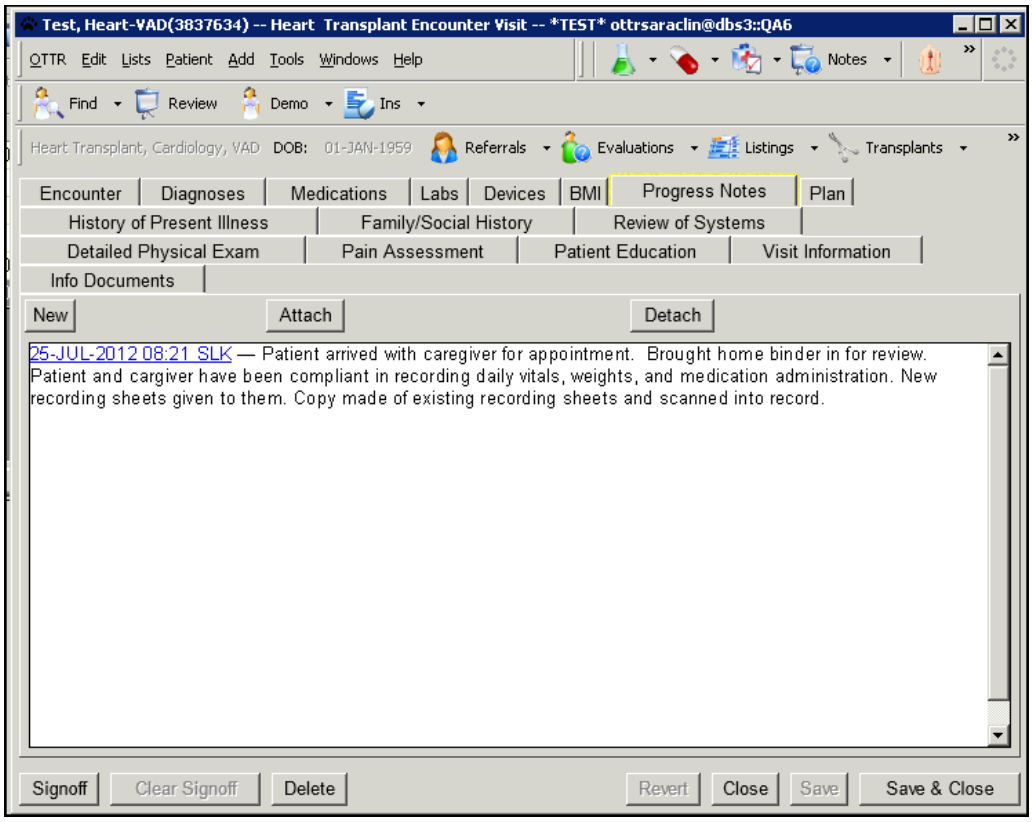
# Progress Notes Tab


Test, Heart-VAD(3837634) -- Heart Transplant Encounter Visit -- *TEST* ottrsaraclin@dbs3::QA6
OTTR Edit Lists Patient Add Tools Windows Help
Notes
Find Review Demo Ins
Heart Transplant, Cardiology, VAD DOB: 01-JAN-1959
Referrals Evaluations Listings Transplants
Encounter Diagnoses Medications Labs Devices BMI Progress Notes Plan
History of Present Illness Family/Social History Review of Systems
Detailed Physical Exam Pain Assessment Patient Education Visit Information
Info Documents
New Attach Detach
25-JUL-2012 08:21 SLK — Patient arrived with caregiver for appointment. Brought home binder in for review. Patient and cargiver have been compliant in recording daily vitals, weights, and medication administration. New recording sheets given to them. Copy made of existing recording sheets and scanned into record.
Signoff Clear Signoff Delete Revert Close Save Save & Close

Progress notes can be entered during the encounter. Once written, they will also display on the Patient Review window. To write a new progress note, click the **New** button. To add an existing progress note to this encounter, click the **Attach** button. To remove a progress note, click on the Detach button and select the progress note you wish to remove.

An example of when to attach an existing note might be that you received notification from their local hospital that the patient had been seen in the ER, which was recorded in an earlier progress note. This encounter or visit may have been a follow up to that event, in which case you may want to attach the information contained in that particular progress note.

**Note:** refer to the notes above in the Diagnoses Tab for Attach and Detach functionality and to the *Progress Notes* document for further information on entering and managing progress notes.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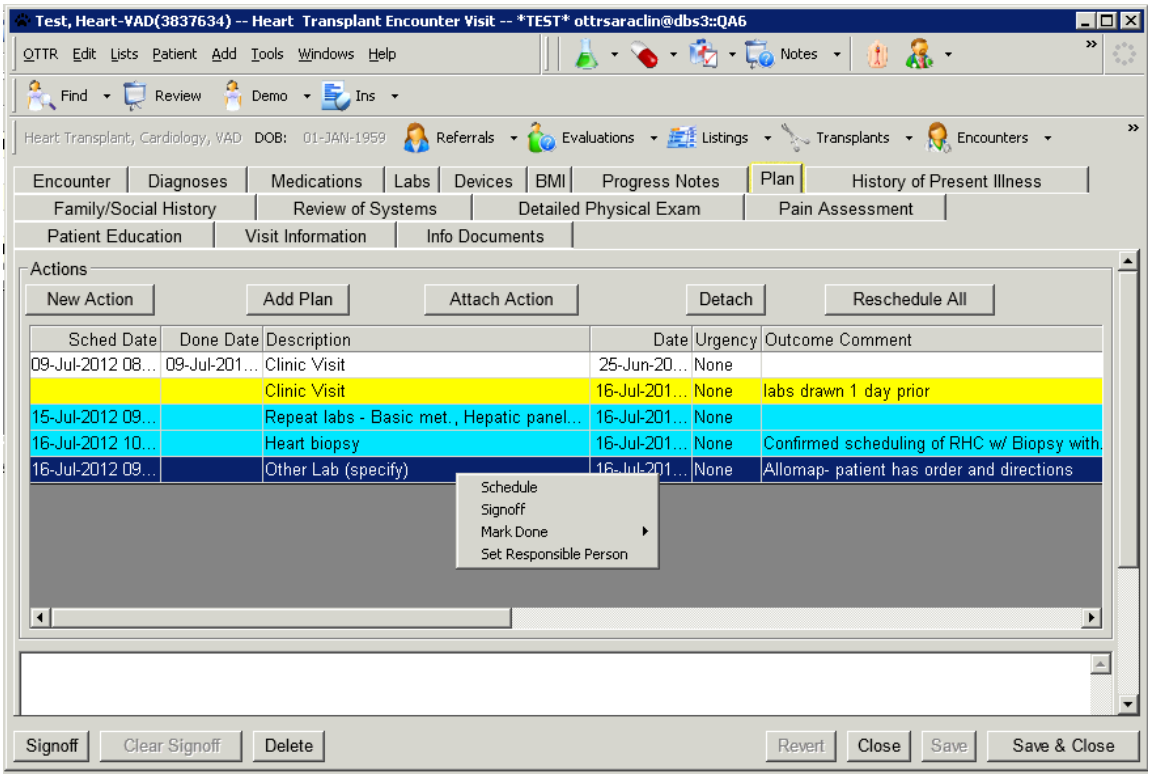
# Plan Tab


Test, Heart-VAD(3837634) -- Heart Transplant Encounter Visit -- *TEST* ottrsaraclin@dbs3::QA6
OTTR Edit Lists Patient Add Tools Windows Help
Notes
Find Review Demo Ins
Heart Transplant, Cardiology, VAD DOB: 01-JAN-1959
Referrals Evaluations Listings Transplants Encounters
Encounter Diagnoses Medications Labs Devices BMI Progress Notes Plan History of Present Illness
Family/Social History Review of Systems Detailed Physical Exam Pain Assessment
Patient Education Visit Information Info Documents
Actions
New Action Add Plan Attach Action Detach Reschedule All
Sched Date Done Date Description Date Urgency Outcome Comment
09-Jul-2012 08... 09-Jul-201... Clinic Visit 25-Jun-20... None
Clinic Visit 16-Jul-201... None labs drawn 1 day prior
15-Jul-2012 09... Repeat labs - Basic met., Hepatic panel... 16-Jul-201... None
16-Jul-2012 10... Heart biopsy 16-Jul-201... None Confirmed scheduling of RHC w/ Biopsy with
16-Jul-2012 09... Other Lab (specify) 16-Jul-201... None Allomap- patient has order and directions
Schedule
Signoff
Mark Done
Set Responsible Person
Signoff Clear Signoff Delete Revert Close Save Save & Close

A plan can contain the standard items ordered by a physician including upcoming clinic appointments, testing needed, or follow up actions. These action items can be added individually using the **New Action** button or as a group of actions called an order-set, action macro, or a plan. The order-sets, created by the OTTR™ Administrator, enables a clinician to quickly add multiple action items to a patient record at once.

To add an order set, select the **Add Plan** button. To attach an action that has already been ordered, select the **Attach Action** button. To remove an action, highlight the desired action and click the **Detach** button. The **Reschedule All** button can be used if you want to reschedule all of the action items at one time.

An example of attaching a previously entered action is shown above. The Clinic Visit action displayed in white was **Attached** to the encounter, then marked 'Done' since the patient arrived for the appointment. Items displayed in blue have been scheduled but not marked 'done', items displayed in yellow haven't been scheduled, and items displayed in white have been scheduled and marked 'done'.

The right click functionality is also present here to manage actions.

**Note:** refer to the note above in the Diagnoses Tab for functionality information and to the *Actions* document for detailed information on adding and managing Actions.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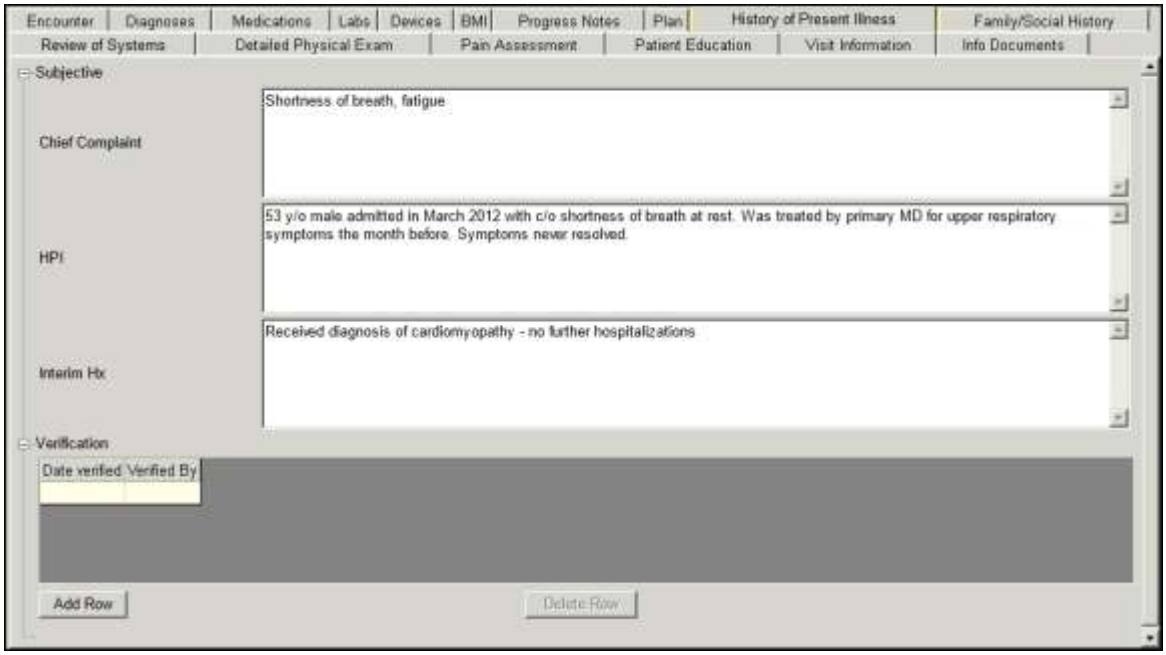
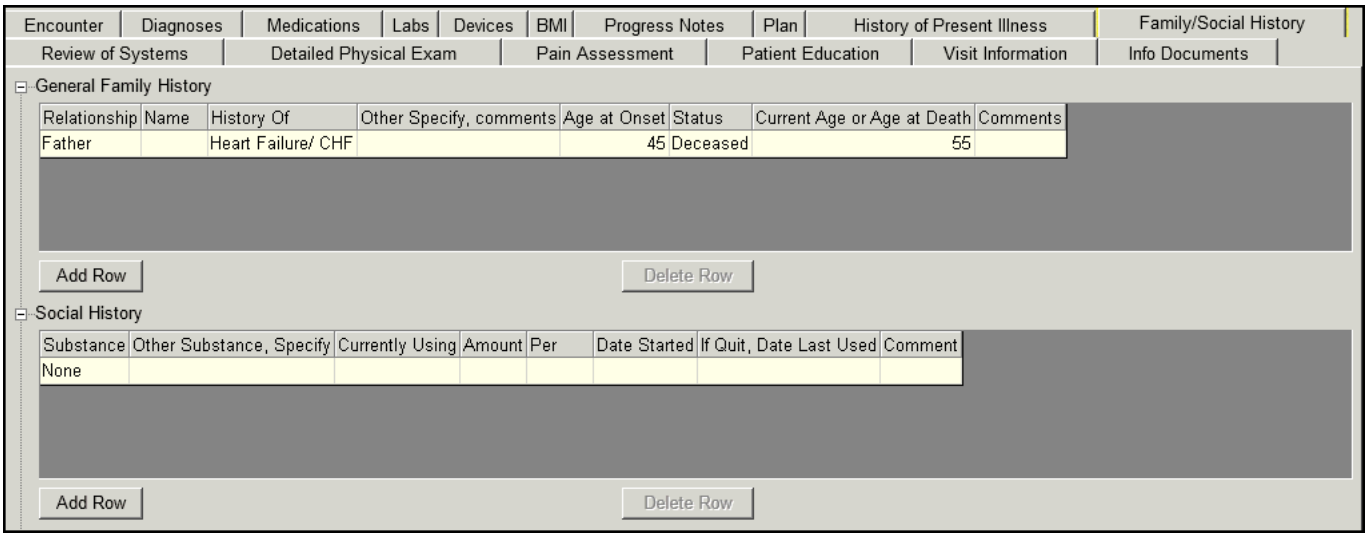
## History of Present Illness Tab




**Chief Complaint**, HPI, and **Interim Hx** fields are all free text boxes available for documenting relevant information. If your site implements a verification process, you can click the **Add Row** button to verify.





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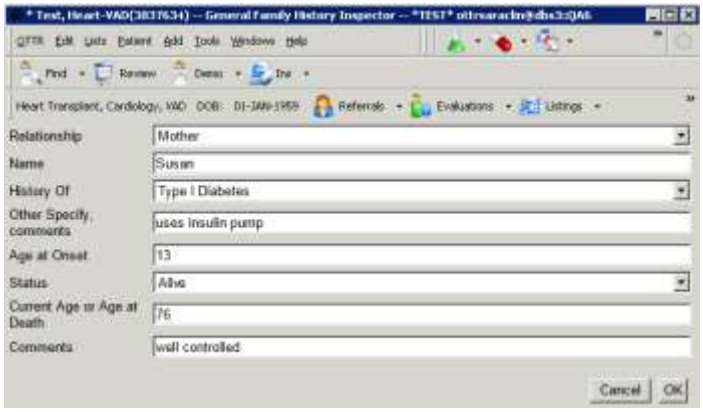
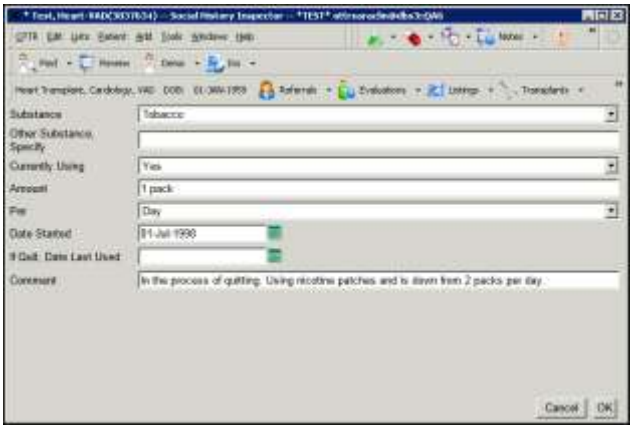
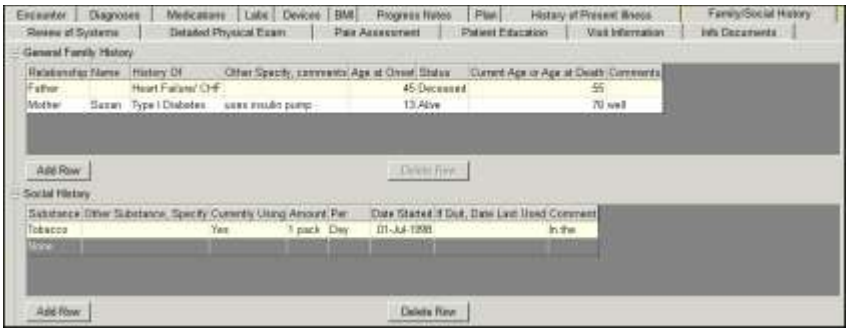
## Family/Social History Tab

Click the Add Row buttons under General Family History and Social History to open up the documentation windows.

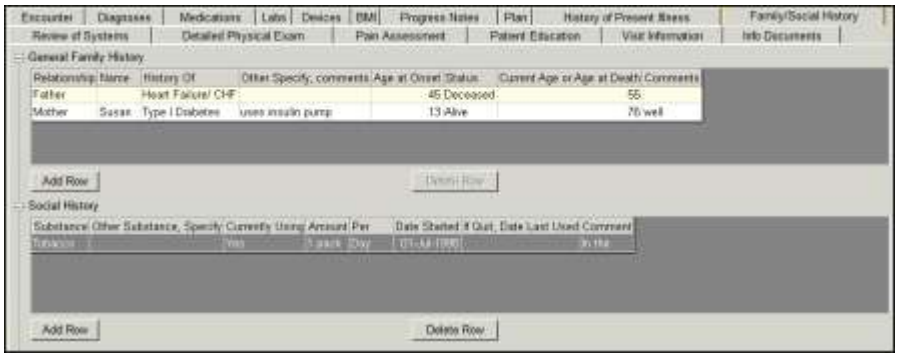



Use a combination of dropdown choices and free text entries to document any family and social history. Click **OK** when finished.




The entries will be displayed in row and column format. To see the full entry, double click on the row that you want to view. To delete an entry, highlight the row and select the **Delete Row** button.




The entry is deleted from view.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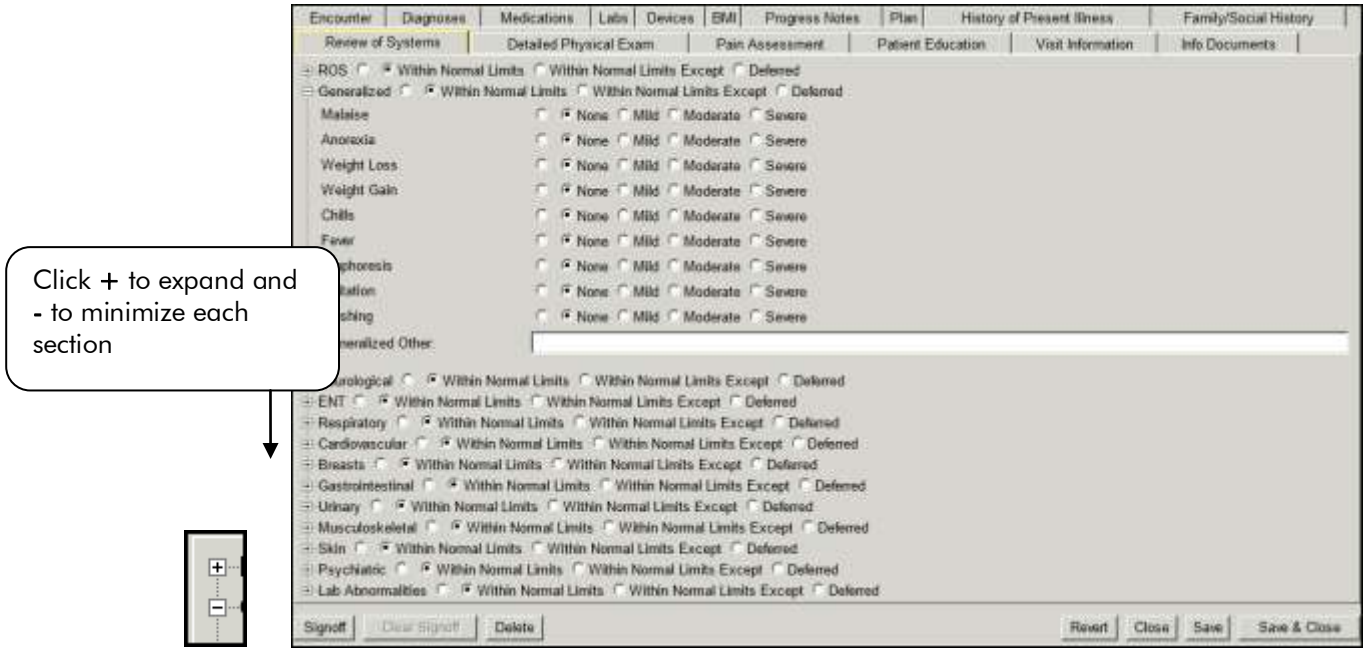
# Review of Systems Tab




The Review of Systems tab consists of a series of radio buttons and free text boxes. Select

to default all responses in that section to **"none".** Select

to default all responses in that section to **"none",** then proceed through the form and mark those items that aren't within normal limits. Select

to defer your assessment for that area.

**Note:** The first section is titled **ROS** and encompasses all sections below it. If you enter one of the options listed above in this section, it will enter that option for **all** sections below. For example, choose the

option, it will enter that option in each section below.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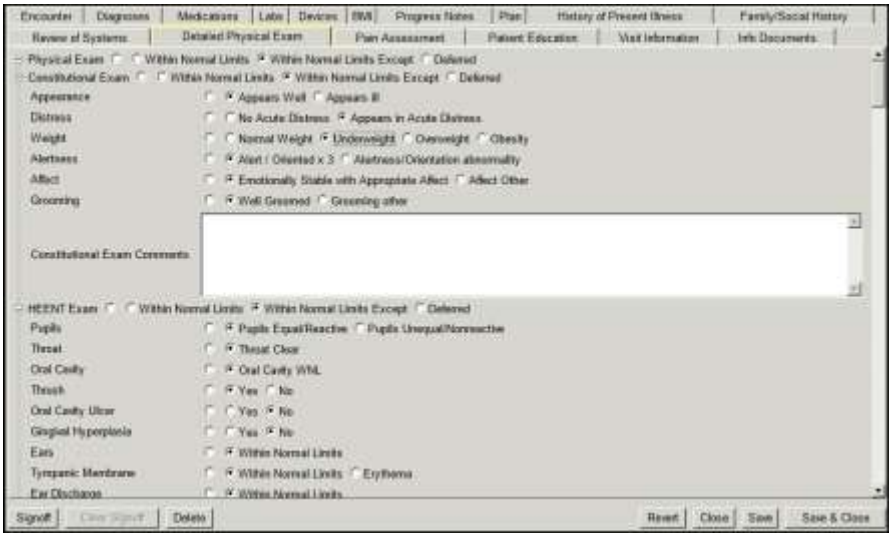
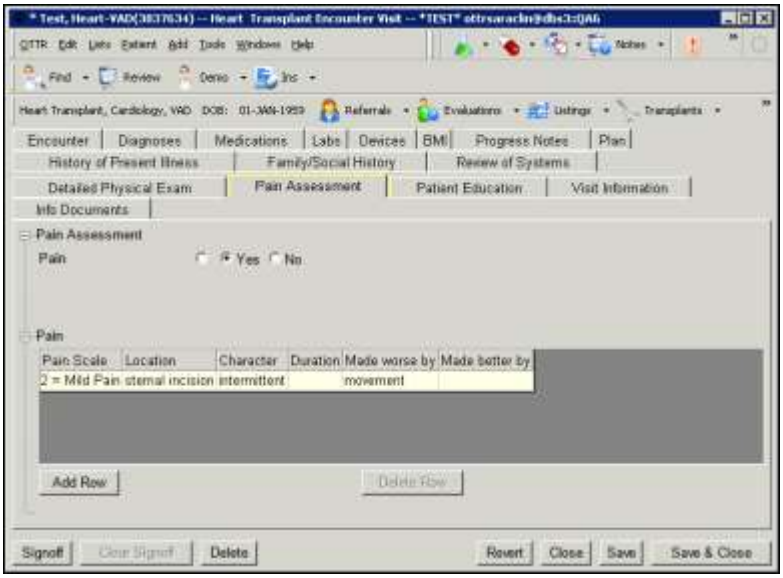
# Detailed Physical Exam




The **Detailed Physical Exam** tab is a collection of radio buttons, free text boxes, and dropdown boxes. It functions in the same manner as the Review of Systems tab in the previous section.

**Note:** The first section is titled **Physical Exam** and encompasses all sections below it. If you enter one of the options listed above in this section, it will enter that option for **all** sections below. For example, choose the

option, it will enter that option in each section below.





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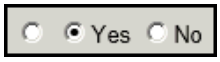
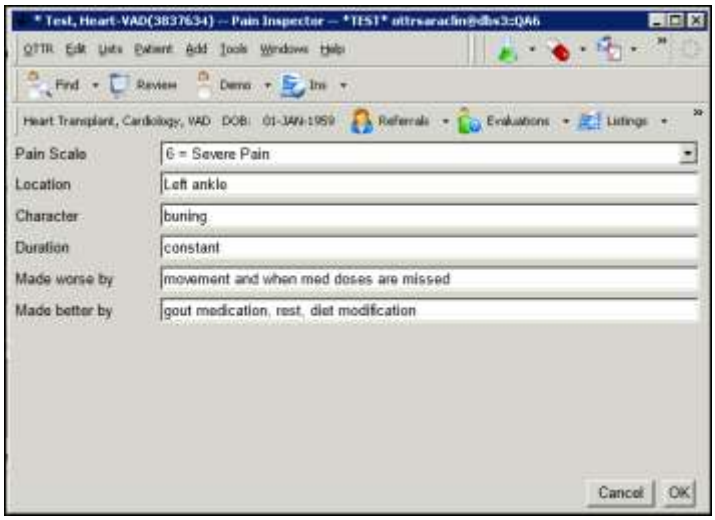
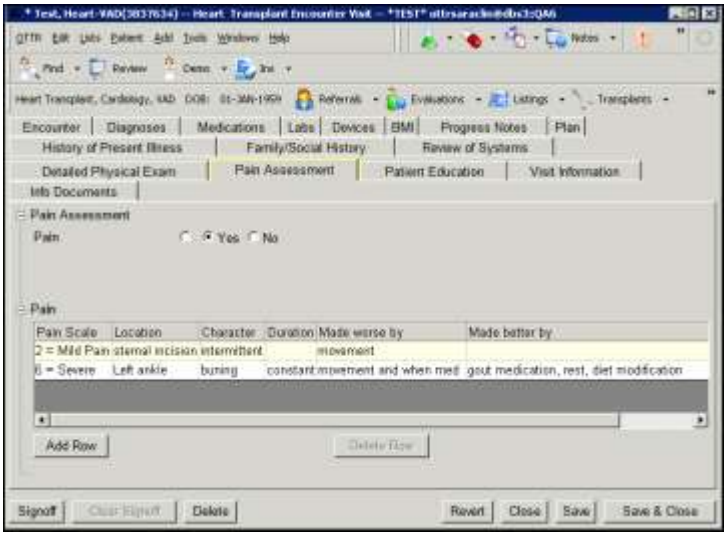
## Pain Assessment Tab

Use the  radio buttons to indicate whether pain is present.






Click the **Add Row** button to open the documentation window and use the dropdown and free text boxes to enter your pain assessment. Click **OK** when finished.




Your assessment is now entered and displayed in row and column format. To see the full entry, double click on the row that you want to view. To delete an entry, highlight the row and select the **Delete Row** button.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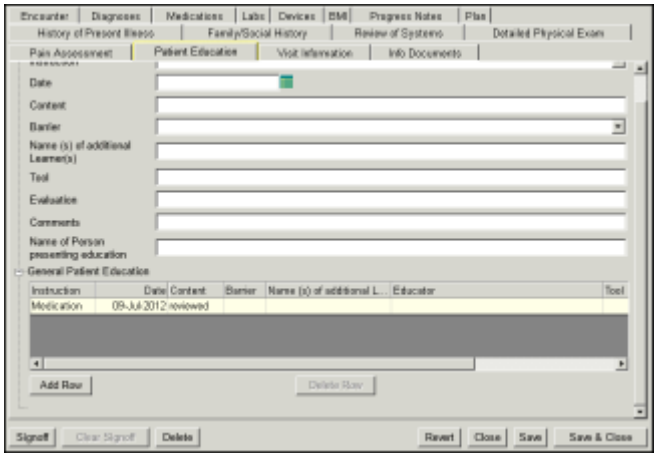
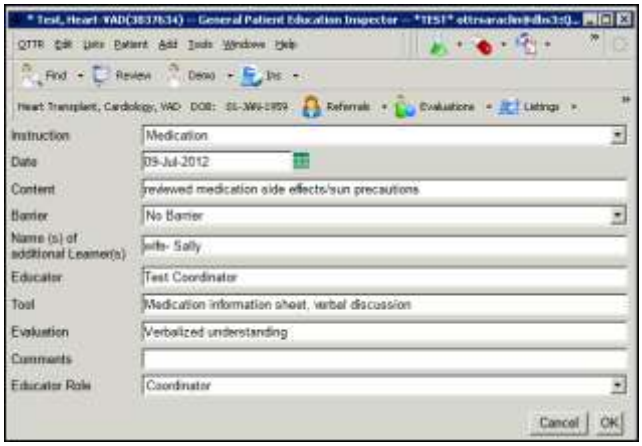
# Patient Education Tab




Click the **Add Row** button to open the documentation window and use the dropdown and free text boxes to enter your pain assessment. Click **OK** when finished.




Your assessment is now entered and displayed in row and column format. To see the full entry, double click on the row that you want to view. To delete an entry, highlight the row and select the **Delete Row** button.

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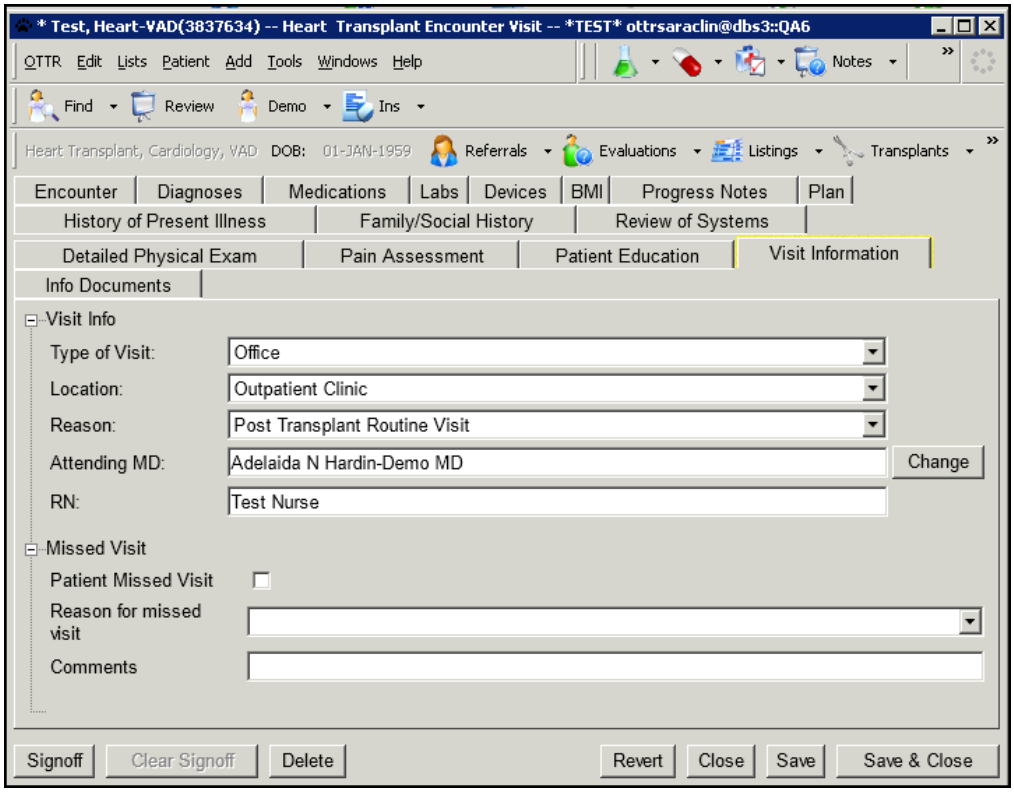
# Visit Information Tab




Enter information regarding this visit or encounter using the free text and dropdown boxes. If the patient missed the appointment, you can document that information here as well.

**Note:** The choices in the dropdown boxes can be modified by your OTTR™ Administrator.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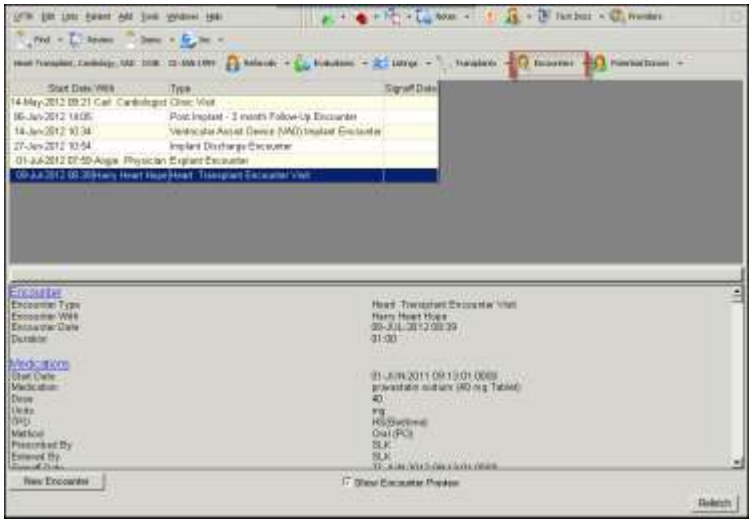
# Viewing and Printing Encounters



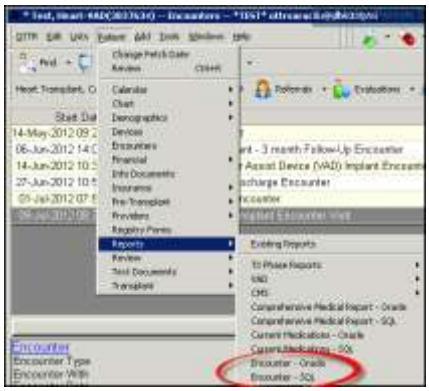
### Viewing Encounters

To access an existing encounter, select the **Encounters** icon or from the **Patient** Master Menu, select **Encounters**.

A list of all encounters which have been added to the patient record will display. Double click on a selected encounter to access the encounter to add or review information in the tabs.

To see a preview of the Encounter, place a check in the **Show Encounter Preview** box in the bottom of the window. You can then highlight the line item, and view the contents of the Encounter in the viewing pane located in the lower portion of the window.

### Printing an Encounter



From the **Patient** Master Menu, select **Reports** then **Encounter.**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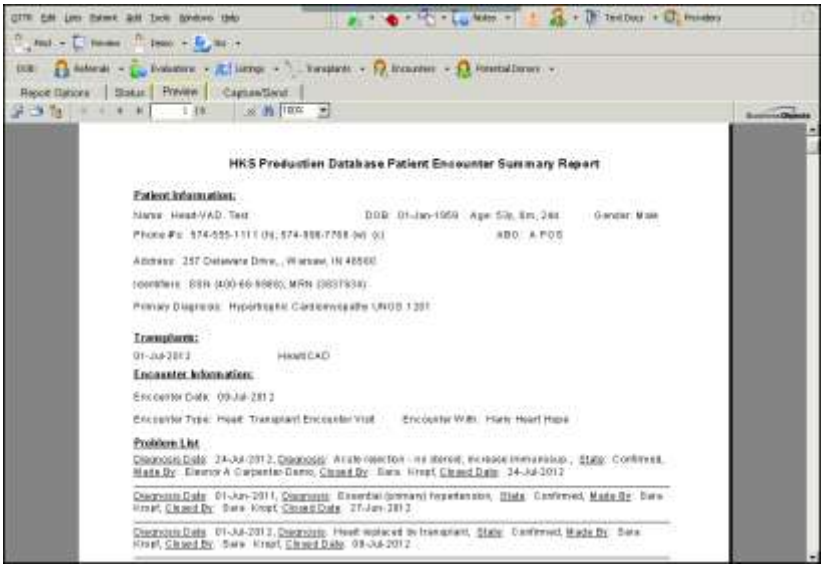
In the **Report Options** you can indicate who you're sending a copy of the encounter to by highlighting the appropriate person. The Letter signed by will auto-populate with the name of the person logged in and can be changed using the **Search** button. Select the encounter you want to print using the dropdown arrow in the **Select Encounter** field. The date that you want labs to pull from can be modified using the green calendar button next to the **Lab Date** field. Select the printer using the dropdown arrow next to the **Printer** field. Enter the **#Copies** to print.

**Auto-Capture** can be automatically checked for those reports or letters that you want captured for future reference. If the report you're trying to print isn't set to Auto-Capture, you can put a check in the box to do so.

Click the **Print** button in the bottom of the window to click your report.





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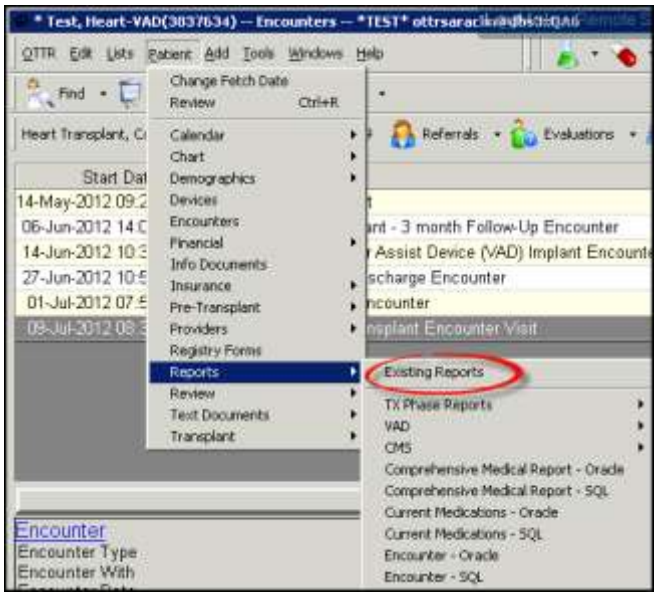
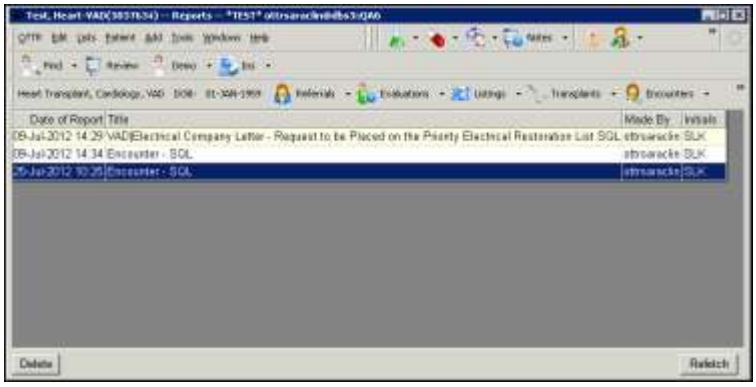
## Auto-capture



Reports (including letters) that are set to **Auto Capture** can be viewed in the Existing Reports feature utilizing the **Patient** Master Menu, selecting **Reports** then **Existing Reports**. Those report or letters can be viewed by highlighting the desired row and double clicking.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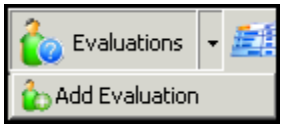
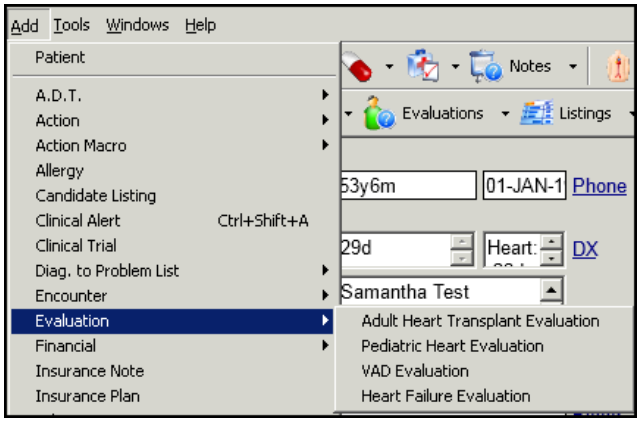
# Evaluations

When a physician determines a referral patient should be evaluated, the clinician must move the patient from the **Referral Phase** into the **Evaluation Phase**. The process followed from referral through evaluation is the same for recipients and living donors.

Moving the patient's through the phases ensures the **Active Referrals** list and the **Active Evaluations** list remains accurate for both the transplant recipient and living donor programs.

To remove the patient from the **Referral** phase, the referral record must have an **End Date** and **End Reason** entered. Adding an evaluation automatically ends the referral phase.




To place the patient into the **Evaluation** phase, add an evaluation record utilizing the **Add Evaluation** option from the **Evaluations** icon dropdown or from the **Add** Master Menu, select **Evaluation**, then select the Evaluation you want to add.

**Note:** your choice of evaluations differ depending on the program(s) you're assigned to.

**For more detailed information managing items in each tab, refer to the following documents: *Encounters, Actions, Labs, Diagnosis, Medications and Progress Notes.*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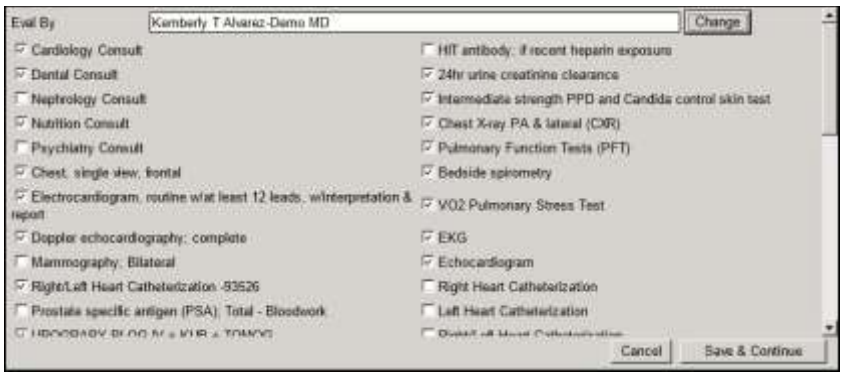


The initial evaluation window displays the most common types of actions ordered for the selected evaluation and the name of the provider evaluating the patient. Click the **Change** button to modify the care provider performing the evaluation.

Place a check in the boxes for the actions you wish to order as part of the evaluation and uncheck any actions that aren't applicable.

**Save & Continue** when finished.


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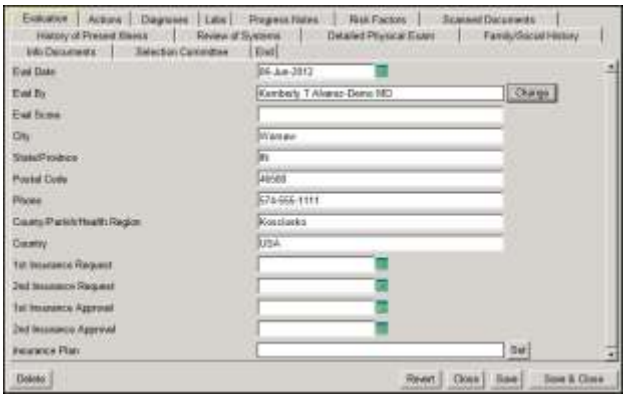
# Evaluation Tab



**Eval Date -** Captures the date the evaluation was added to the patient's record.

**Eval By -** Displays who evaluated the patient.

**Eval Score -** Enter an evaluation score if applicable for the type of evaluation being performed.

**Demographics -** Current patient demographic information is auto populated into the demographic fields. If the patient's demographic information was not present within the record at the time this evaluation was created then these fields may be manually updated.

Insurance request and approved fields are provided to document key financial insurance dates if your site doesn't have the OTTR™ Financial Module.

**1st Insurance Request**– Click on the green calendar to enter a date.

**2nd Insurance Request**– Click on the green calendar to enter a date.

**1st Insurance Approval**– Click on the green calendar to enter a date.

**2nd Insurance Approval**– Click on the green calendar to enter a date.

**Insurance Plan** – Use the **Set** button to select the patient's primary insurance provider from the associated insurance providers currently attached to the patient's record.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## Actions Tab

Actions ordered from the initial evaluation window display here. Click the **New** button to order a new action. Click the **Attach** button to attach previously ordered actions. Click the **Detach** button to detach or remove actions from the evaluation phase.

Actions displayed in **Yellow** haven't been scheduled and will appear on the schedulers **Lists|Actions|Pending Pre-Testing|Eval- Unscheduled** list.

Actions displayed in **Blue** have been scheduled but not completed and marked done. They will appear on the transplant coordinators **Lists|Actions|Pending Pre-Testing|Eval-Not Done** list.

Actions displayed in **White** have been scheduled, completed and marked done.

Some sites choose to copy and paste or manually enter the test summary in the **Comment** field of an evaluation action.

| | | | | | |
|---|---|---|---|---|---|
| 04-Jun-2012 0... | 05-Jun-20... | Surgical Consultation | 27-Jun-20... | None | |
| 04-Jun-2012 0... | 05-Jun-20... | Social Service Consult | 27-Jun-20... | None | Cleared for transplant. |
| 04-Jun-2012 0... | 05-Jun-20... | Dietician Consult | 27-Jun-20... | None | |

Doing so allows the committee to review each action along with a brief result and displays on the **Patient|Reports|Tx Phase Report\Evaluation** which is used to update the referring provider or present the patient at the Selection Committee Meeting.


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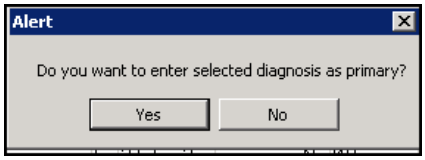
## Diagnoses Tab

The primary diagnosis entered during the referral process displays in the **Primary Diagnosis** field. The physician performing the evaluation may choose to change this to another more appropriate diagnosis if needed. This should be a UNOS diagnosis which drives the need for the transplant.

Both the **Referral** and **Evaluation** records will maintain the **Primary** diagnosis which were entered at that time. If the primary diagnosis is changed in the phase, upon saving an alert will display.




If you select **Yes**, the primary diagnosis in the **General Medical** window will update to the newly entered diagnosis. If you select **No**, the **General Medical** window won't be updated. If the patient's primary diagnosis should be changed later under the patient's **General Medical** window it will not alter the referral and evaluation records. They are maintained for historical and reporting purposes.

Use the **Change** button to add a **Primary**, **Secondary** or **Tertiary** diagnosis.

Use the **New** button to add a new **Problem List** diagnosis not previously documented in the patient's record,.

Use the **Attach** button to attach a diagnosis previously documented in the patient's **Problem List** diagnoses area.

Highlight a diagnosis and click on the **Detach** button to remove a **Problem List** diagnosis from the evaluation record.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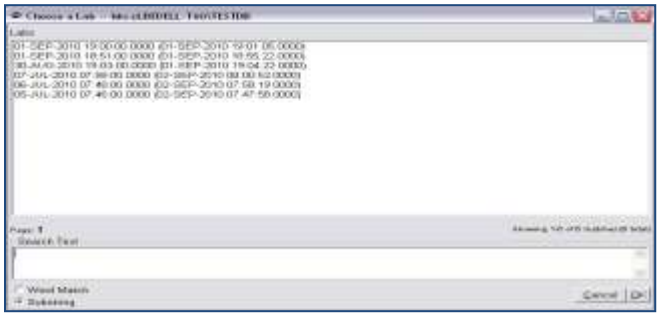
## Labs Tab

Click the **New** button to add a new lab result specific to this evaluation.

Click the **Attach** button to attach a lab result previously entered into the patient 's record.

To remove a lab result from this window, highlight it and click on the **Detach** button.

Instead of copying and pasting lab results into the lab actions ordered for the patient's evaluation, the transplant coordinator will attach the lab results here by clicking on the **Attach** button.



To select one result, highlight it and click on the **OK** button.

To select a range of results, highlight the first lab and hold down the **Shift** key and click on the last lab. All labs between the two selected will become highlighted. Click **OK**.

To select multiple labs individually, highlight a lab and hold down the **Ctrl** key and select the remaining labs. Click **OK**.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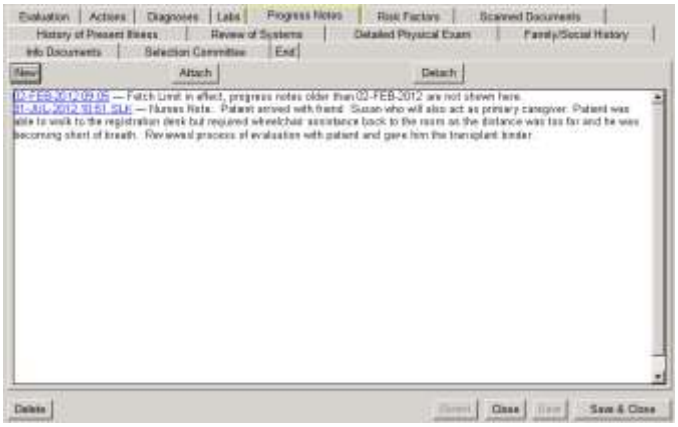
## BMI Tab

Click the **New** button to add the patient's Height and Weight. OTTR™ performs an auto calculation for the BMI and BSA.

To attach a previous BMI click the **Attach** button.

To remove a BMI from this record, highlight it and click the **Detach** button.



## Progress Notes Tab

Click on the **New** button to add a new progress note in the patient's evaluation record. This will also display on the patient review window.

Click on the **Attach** button to attach a progress note which was previously entered into the patient record.

Highlight the note and click on the **Detach** button to remove a progress note from this evaluation.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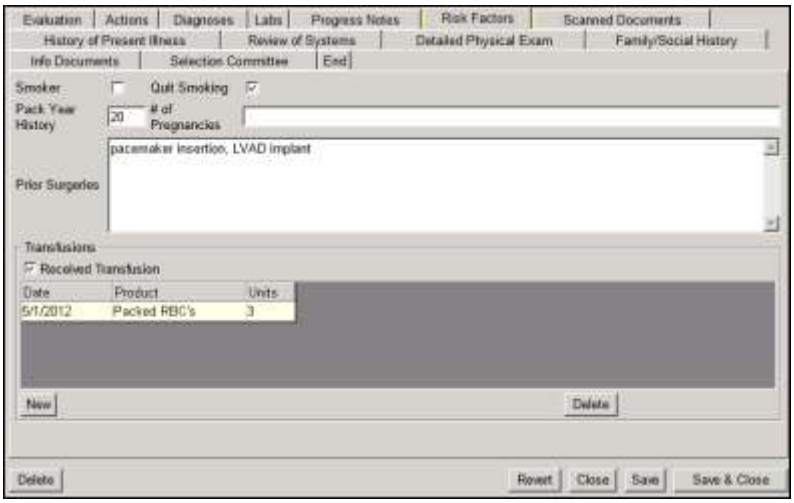
## Risk Factors Tab




**Smoker** – Placing a check mark within the box indicates a yes answer.

**Quit Smoking** - Placing a check mark within the box indicates a yes answer.

**Pack Year History** – Enter the patient's pack year history number.

**# of Pregnancies** – Enter the number of pregnancies if this is a female patient.

**Prior Surgeries** – Information displayed here pulls from **Patient|Chart|RiskFactors** if previously completed. This area also populates the **Previous Surgeries** field in Candidate Listing record.

**Received Transfusion** – When you add transfusion information using the New button, this box will auto-check.

To add transfusion history click on the **New** button.

To remove transfusion history, highlight the row and click the **Delete** button directly across from the **New** button.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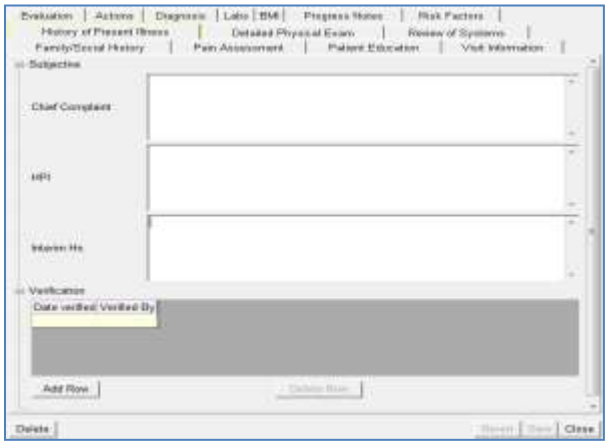
## History of Present Illness Tab



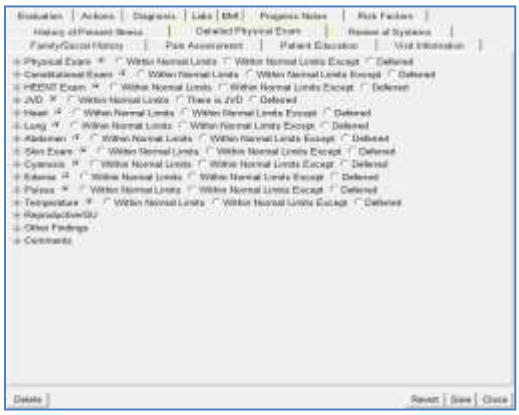
**Chief Complaint**– Free text field.

**HPI**– Free text field.

**Interim Hx**– Free text field.

To add a verification click on the **Add Row** button. To remove a verification, highlight the row and click on the **Delete Row** button.

## Detailed Physical Exam



Information captured here is considered to be discrete data which can be pulled later for research or report purposes. Some physician's choose to scan or attach a dictated report in lieu of using this tab.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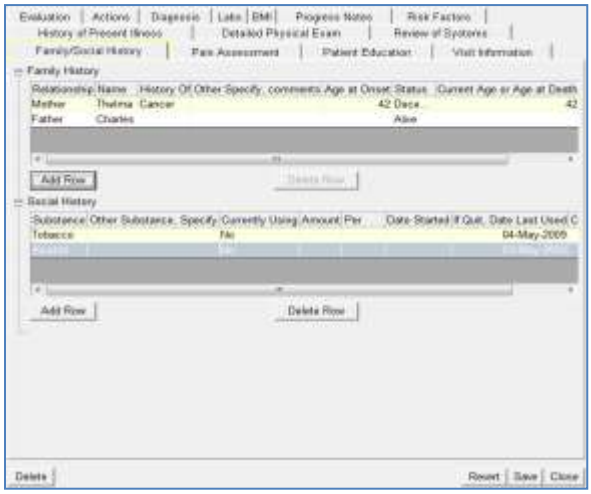
## Review of Systems Tab

Information captured here is considered to be discrete data which can be pulled later for research or report purposes. Some physician's choose to scan or attach a dictated report in lieu of using this tab.

## Family/Social History Tab




To add family history, click on the **Add Row** button. Here is where you may add family members and document their known health issues.

To add social history, click on the **Add Row** button. Here you may enter drug, tobacco and alcohol substance abuse.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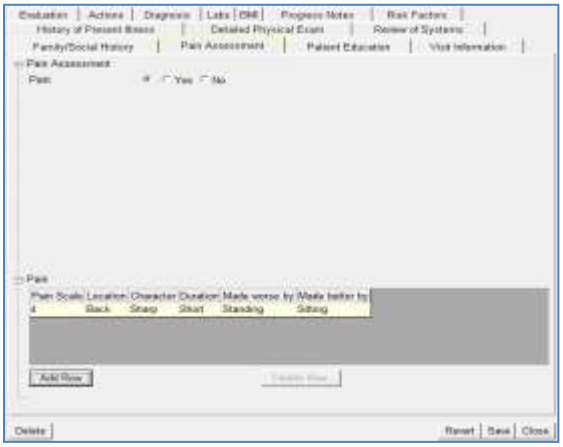
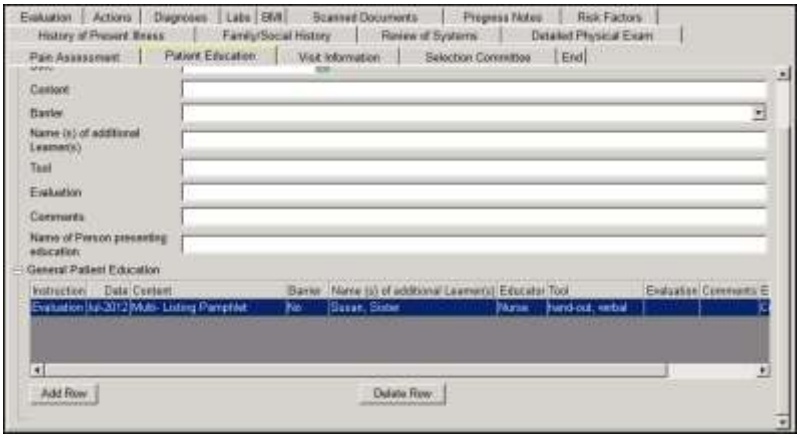
## Pain Assessment Tab

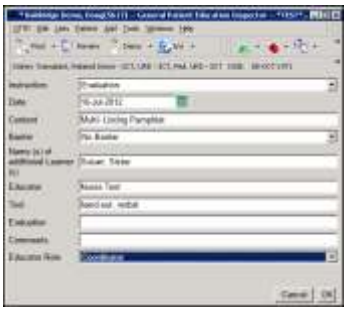


**Pain** – Select the **Yes** or **No** radio button.

To add information specific to the pain click on the **Add Row** button. To remove pain information, highlight the row and click on the **Delete Row** button.

## Patient Education Tab





Use the **Add Row** button to document detailed education given to the patient and family.

Highlight the row and click the **Delete Row** button to remove.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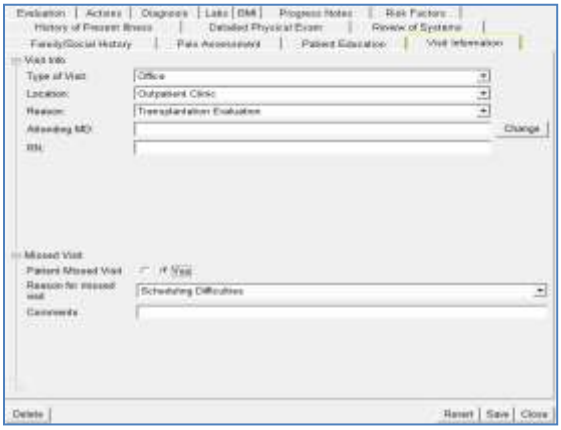
## Visit Information Tab



**Type of Visit** – Use the drop-down arrow to make a selection.

**Location** – Use the drop-down arrow to make a selection.

**Reason** – Use the drop-down arrow to make a selection.

**Attending MD** – Click on the **Change** button to select the attending physician.

**RN** – Enter the attending RN's name

**Patient Missed Visit** – Click on the **Yes** radio button if the patient missed the appointment.

**Reason for missed visit** – Use the drop-down arrow to make a selection.

**Comments** – Free text field.

**Note:** Your OTTR™ Administrator can modify the selections available in the dropdown boxes to meet your center's needs.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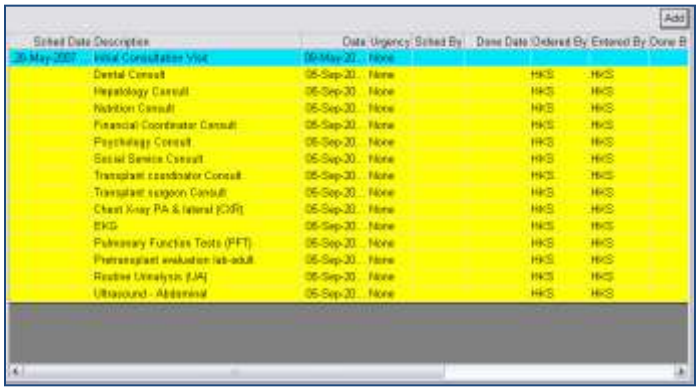
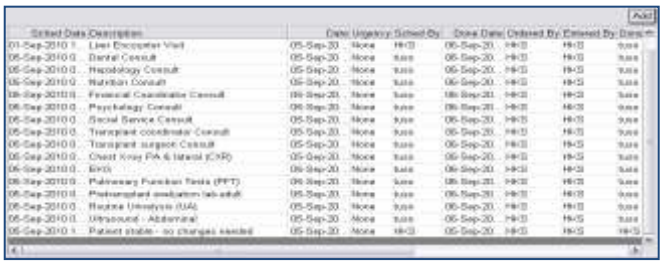
# Preparation for Selection Committee

To determine which patient's record is ready to be presented at the committee, the coordinator must first ensure all of the ordered actions have been completed.

Use the **Lists** Master Menu to access the open evaluations. **Lists|Evaluations|Open Evaluations list**. Highlight a row within the list to activate the patient's record. Click on the **Actions** icon to open the patient's action window.





Notice in the first example, actions have been ordered but need to be scheduled (Yellow). There is one action which has been scheduled but not yet marked done (Blue). This patient's record is not ready to be presented at the committee meeting.

In the second example all of the evaluation actions have been marked done (White). When all of the evaluation actions have been completed, the patient is ready to be presented at the **Selection Committee** meeting. Add an action of **Selection Committee** to the patient's record and schedule it for the next meeting's date.

The **Lists|Actions|Pending Actions- Not Done** list can be used to sort all patient's with that open action letting you know who's ready for presentation.

On the day of the meeting, access **Lists|Evaluations|Open Evaluations** list and **Double Click** on the row in this list to open the patient's evaluation record.

The committee will review each tab of the evaluation record. Under the **Actions** tab the presenter can review the comment section of each action with the committee. For more detailed information, access the **Text Docs** to open full views of scanned or interfaced documents.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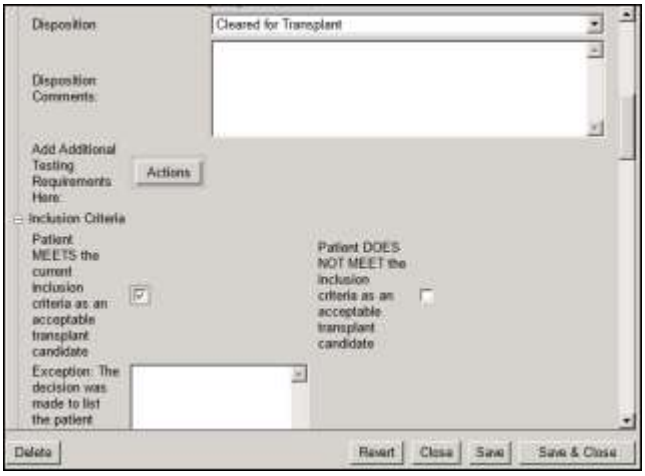
## Selection Committee Tab

Once a decision has been made, the disposition can be documented in the **Selection Committee** form.




**Date of Review** - Enter the date of the committee meeting.

**Transplant Candidacy Being Considered for** - Use the dropdown to make your selection.

**Additional Organs** - If the patient is being conisdered for a multi-organ transplant, place a check in the appropriate additional actions.

**Dispsition** - Use the dropdown to select the disposition for transplant or implant.

**Additional Testing Requirements** - Click the **Actions** button to be re-directed to the Actions window to add any additional testing or consults the patient might need.

**Patient MEETS or DOES NOT MEET inclusion criteria** - Place a check in the appropriate box.

**Exception** - If an exception is being made for the patient, document the information here.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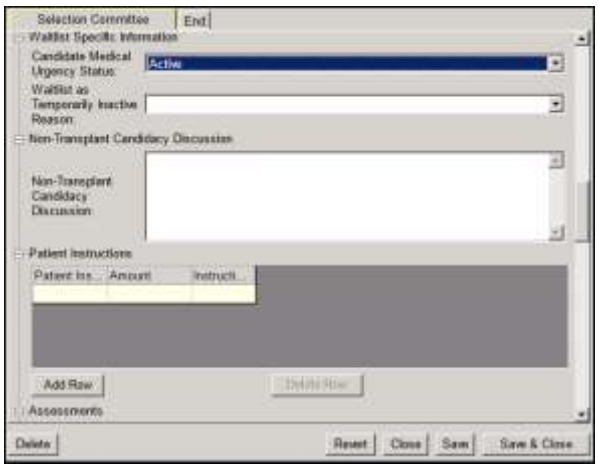
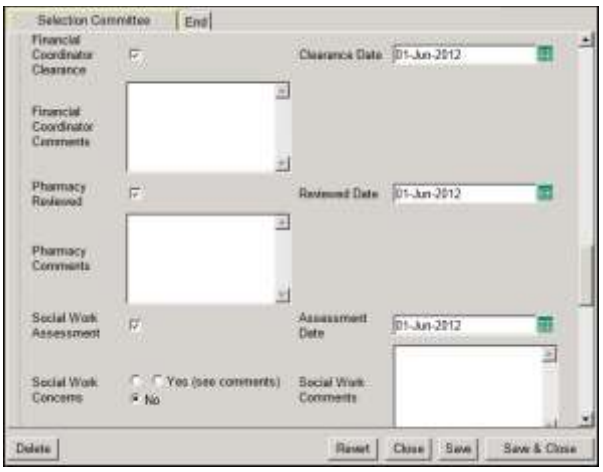


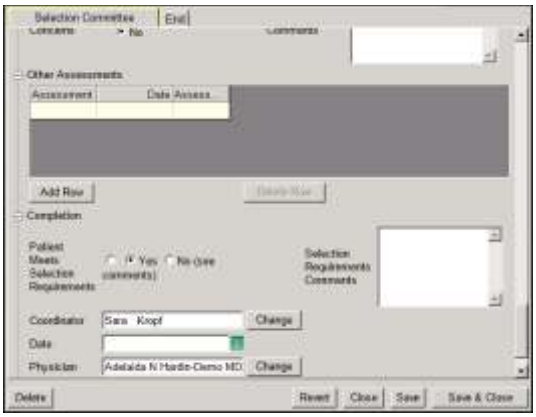

**Urgency Status** - Use the dropdown to select listing status.

**Waitlist as Temporarily Inactive** - If temporarily inactive, select the reason using the dropdown.

**Non-Transplant Candidacy Discussion** - If the patient is not a candidate, document the specific discussion and reasons.

**Patient Instructions** - Use the **Add Row** button to document any patient instructions given regarding listing, further testing need, etc

**Committee Clearance** - Use the provided fields to document the individual multi-disciplinary decisions and concerns.




At the bottom of the form, document the name of the primary coordinator and physician committee leader using the **Change** buttons. Once saved, the form can be found under in the **Text Docs** area and printed. Some sites choose print this document, have it signed by all committee members, and scan the signed copy back into the patient record.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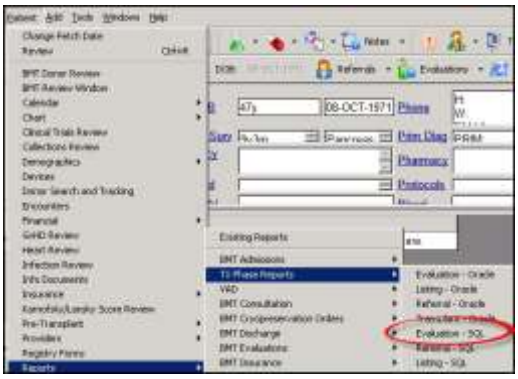
## Evaluation Report

If you're unable to present the patient electronically using the OTTR™ application. A report may also be printed for each patient record being presented which displays all of the information entered into the evaluation record. This report may be used during the committee meeting or can be sent to the referring provider as an update.



To access the report from the Patient Master Menu, select **Reports,** select **Tx Phase Reports,** then **Evaluation**.

Select whether or not you want to print a **Cover Letter**.

Highlight the **Care Provider** you're sending the report to. Be sure that you have this type of care provider assigned to the patient as it will pull this information into the report.

Use the Search button to indicate who is **Signing** the report.

Use the green calendar button to choose a starting **Lab** date.

Select the **Printer** from the dropdown and enter the **# of Copies**, then select **Print**.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9/6/2010

Paul Refmd Canyon
2325 West Maple
Cadar, WA 48375

Dear Dr. Canyon:

Thank you for your referral of Pilar S Baan-Cerro who was evaluated in our clinic on 8/30/2010. An evaluation report is attached. We appreciate your confidence in our ability to serve your patient's needs. We will be keeping you informed of Pilar's progress. If you have any questions please contact our office.

Sincerely,

Test User

If running the report for the referring provider, above is an example of the standard ***Cover Letter***.

**HKS Production Database Patient Evaluation Summary Report**

| | | | |
|---|---|---|---|
| **Name:** | Pilar S Baan-Cerro | **MRN:** | X225073 |
| **Evaluation Date:** | 30-Aug-2010 | | |
| **Evaluation By:** | Lisa Bedell | | |
| **End Reason:** | Listed for Transplant | | |
| **End Date:** | 08-Sep-2010 | | |
| **Ended By:** | | **City:** | Omaha |
| **Evaluation Score:** | | **State/Province:** | NE |
| | | **Postal Code:** | 68064 |
| **Insurance Plan:** | | **County:** | Douglas |
| | | **Country:** | USA |
| **1st. Ins. Request:** | | **Phone:** | 402-333-2222 |
| **1st. Ins. Approval:** | | | |
| **2nd. Ins. Request:** | | | |
| **2nd. Ins. Approval:** | | | |

**Actions**

| Date Scheduled | Description | Order By | Done Date | Done By | Outcome | Comment |
|---|---|---|---|---|---|---|
| 05-Sep-2010 8:45 am | Dental Consult | HKS | 05-Sep-2010 | lusa | Acceptable | |
| 05-Sep-2010 8:25 am | Hepatology Consult | HKS | 05-Sep-2010 | lusa | Acceptable | Result of the consult may be copied and pasted or manually entered inside the comment box of the "Hepatology Consult" action. |
| 05-Sep-2010 8:28 am | Nutrition Consult | HKS | 05-Sep-2010 | lusa | Acceptable | Result of the consult may be copied and pasted or manually entered inside the comment box of the "Nutrition Consult" action. |
| 05-Sep-2010 8:29 am | Financial Coordinator Consult | HKS | 05-Sep-2010 | lusa | Acceptable | Result of the consult may be copied and pasted or manually entered inside the comment box of the "Financial Coordinator Consult" action. |
| 05-Sep-2010 8:30 am | Psychology Consult | HKS | 05-Sep-2010 | lusa | Acceptable | Result of the consult may be copied and pasted or manually entered inside the comment box of the "Psychology Consult" action. |
| 05-Sep-2010 8:31 am | Social Service Consult | HKS | 05-Sep-2010 | lusa | Acceptable | Result of the consult may be copied and pasted or manually entered inside the comment box of the "Social Service Consult" action. |

The evaluation report displays all information entered into the patient's evaluation record.


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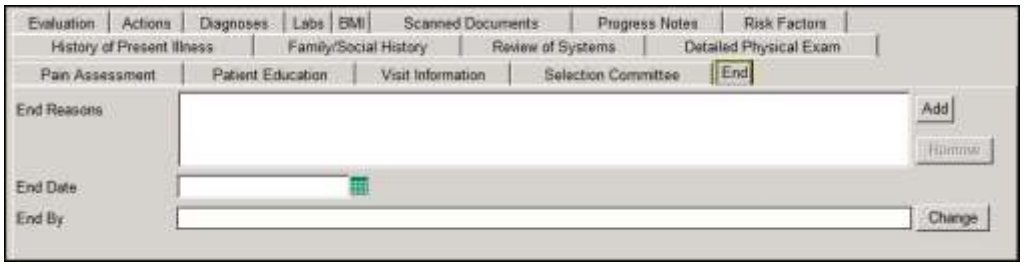
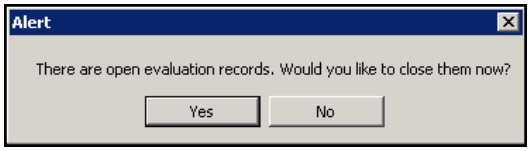
## Ending the Evaluation



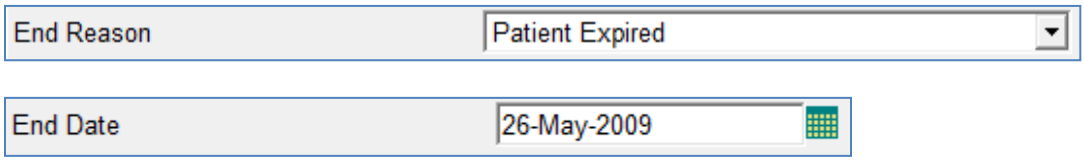

When a **Candidate Listing** is added and saved to a patient's record which has an open evaluation, the following message window will display.




Selecting **Yes** will automatically enter an end date of today's date and an end reason of **Listed for Transplant** into the patient's open evaluation record.

This saves the clinician from having to manually close the open evaluation record.

### Manually Ending an Evaluation




If it's determined that a patient currently within the evaluation phase will not be listed for transplant, the clinician must manually close the open evaluation record by entering an end reason and an end date into the evaluation record.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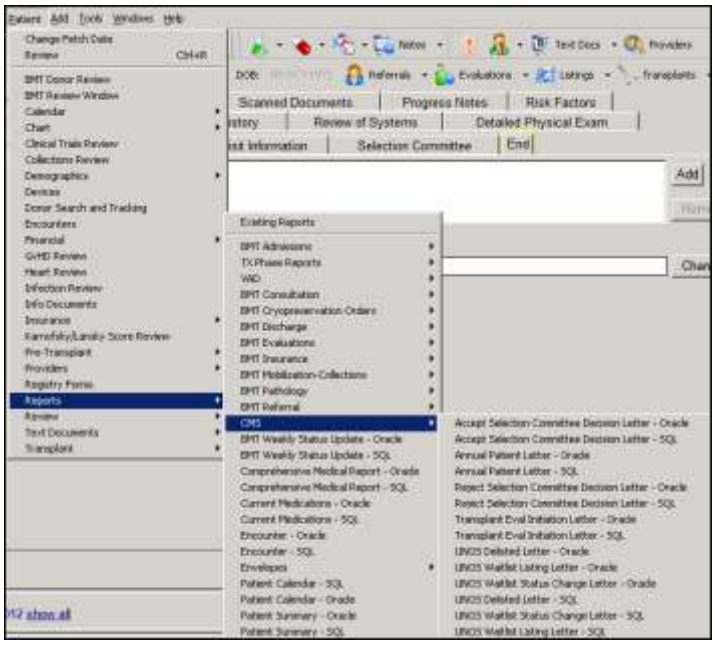
## Evaluation Letters

Letters can be sent to the patient informing them of the committee decision. During or after the selection committee meeting, the presenter can add **Selection Committee Acceptance** or **Rejection** actions to the record and assign them to the person responsible for generating the letters to serve as a task or reminder.




Letters can be accessed using the **Patient** Master Menu, select **Reports**, select **CMS**, then select the desired letter.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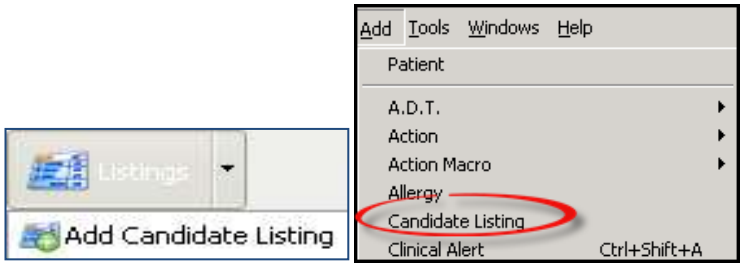
# Listings

Once a patient is evaluated and determined to be an acceptable transplant candidate, the patient is listed with UNOS and the **Listing** is added to the OTTR™ patient record. In the case of a multi-organ transplant, separate listing events may need to be added.




A Listing can be added from the **Listings** icon dropdown or from the **Add** Master Menu, select **Candidate Listing**.

Once you begin to enter listing information and **Save**, an alert will appear allowing you to automatically end the evaluation.

**Note:** some of the fields are applicable to certain types of transplants and may not be used by your site. Additionally, your site will determine which fields you'll use and which you'll disregard.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## Listing Tab

**Listing Date** – Displays the date the **Candidate Listing** record was added. You may want to modify this to match your UNOS listing date and time.

**Listed By** – Displays the name of the who added the candidate listing to the patient record. If you added the listing in UNOS, you may also want to be the person adding the listing in OTTR™.

**Organ Type** – Use the dropdown to select the organ type the patient will be transplanted with.

**Listing Code** – Click on the drop-down arrow to select a listing code. This field won't be activated until an organ type is selected.

**Code Start Date** – Displays the date and time the listing code was entered or changed.

**Number of Cross Matches** – Enter the number of cross matches.

**Listing Extra Days** – Enter the extra listing days if applicable.

**Eval Score Date** – Enter the date the patient's evaluation score was determined if applicable.

**Donor Height Range** – Enter the desired donor height range.

**Lung Lobes** – Click on the drop-down arrow to select lung lobe(s) you wish to make a comment about.


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**Comment** – Enter a desired comment about the selected lung lobe(s).

**Previous Surgeries** – Displays information that was entered in the patient's **Risk Factors**.

**Special Considerations** – Enter any special considerations for this candidate listing record.

**Option Boxes** – Place a checkmark in the option boxes which are appropriate for this candidate listing record.

**Other Listings Button** – Clicking on this button displays the patient's previous candidate listings.

**Ready for Transplant** – Place a checkmark in the **Ready for Transplant** when applicable.

**Mark Ready By** – Displays the clinicians name who selected the **Ready for Transplant** option box.

**Insurance Authorization** – Enter the patient's authorization number for transplant.

**Form Submission Date** – Enter the date the Transplant Registry form was formally submitted.

**Transplant Number** – Automatically displays what number this transplant is for the patient.

**Evaluation Score** – Enter the patient's evaluation score is applicable.

**Donor Weight Range** – Enter the desired donor weight range.

**Donor Age Range** – Enter the desired donor age range.


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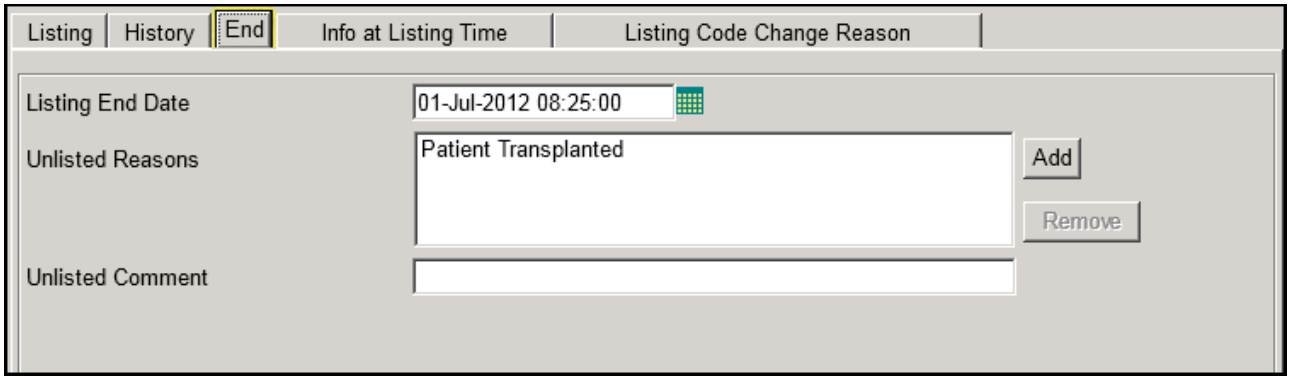
## History Tab

Each time the patient's listing code is changed under the **Listing** tab a history is created and stored here.

## End Tab




**Listing End Date** – Displays the date the candidate listing was ended.

**Unlisted Reasons** – Use the Add button to select reasons for ending the listing.

**Unlisted Comment** – Is a free text field.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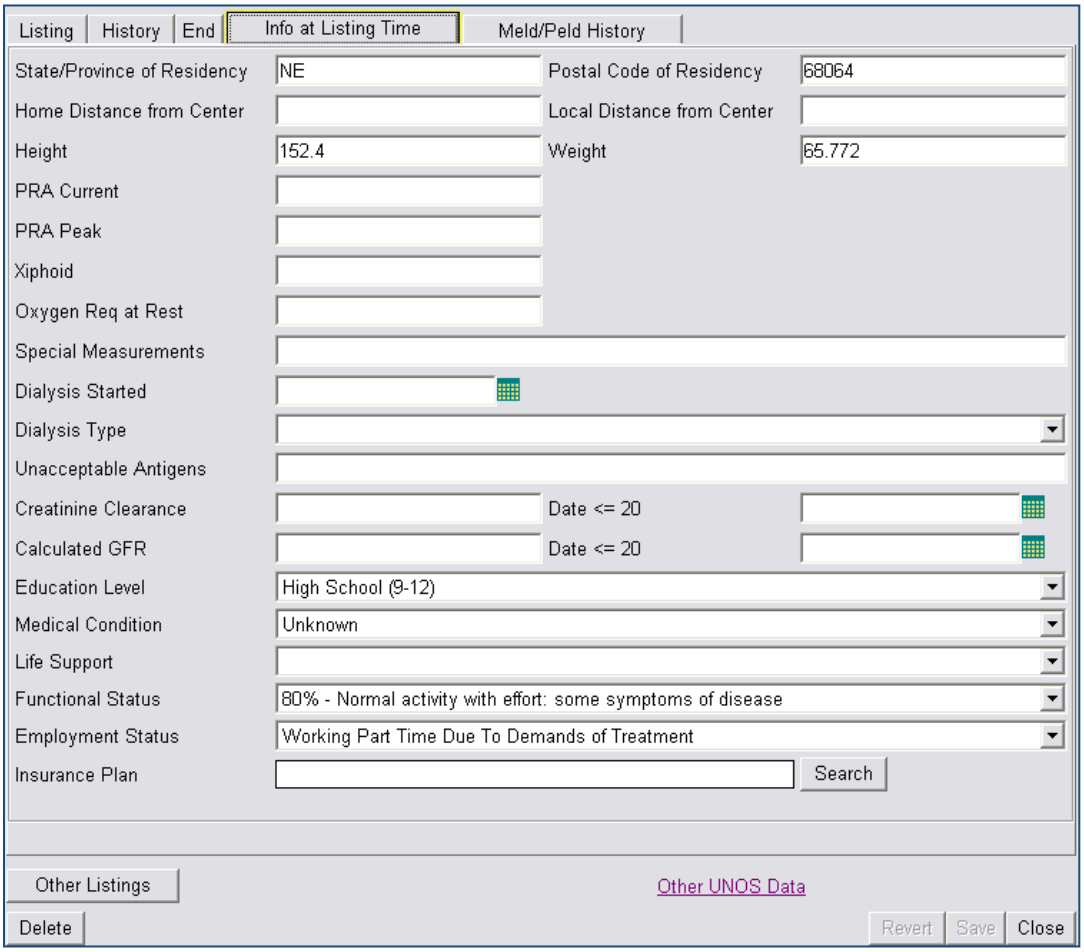
# Info at Listing Time Tab




When the **Candidate Listing** record was added, this tab is auto populated based upon the information currently contained in the patient's record.

The clinician has the ability to update fields manually if needed.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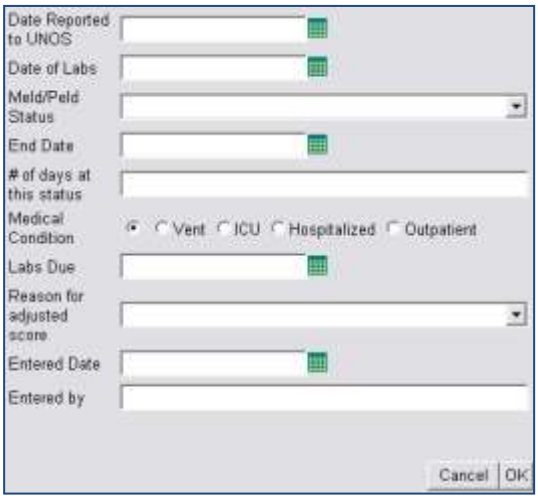
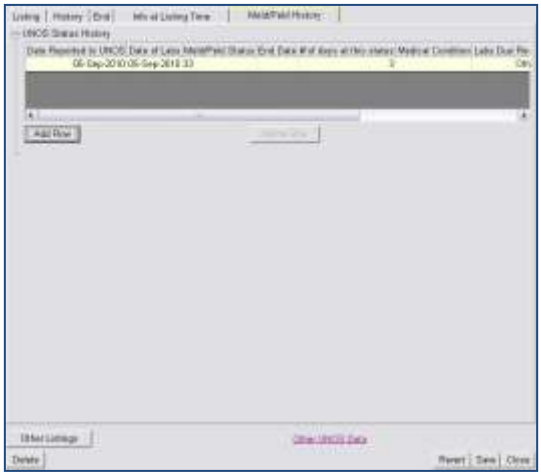
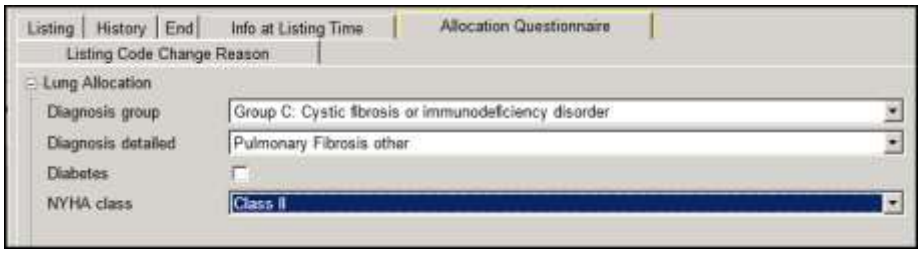
## Additional Tabs






Depending upon the type of transplant to be performed, special tabs may be added to the candidate listing record to document organ specific details.

In an example above, a liver transplant is to be performed. The **Meld/Peld History Tab** is an example of a special tab which was added.

Clinicians will click on the **Add Row** button to document each time the patient's Meld/Peld score has changed.

In another example, lung transplant listings include an **Allocation Questionnaire** to be completed.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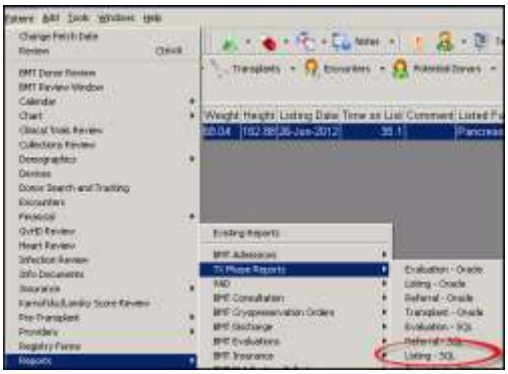
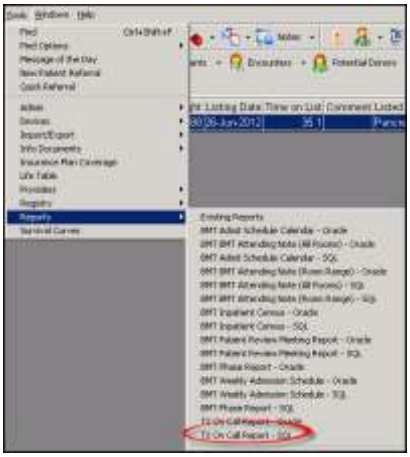
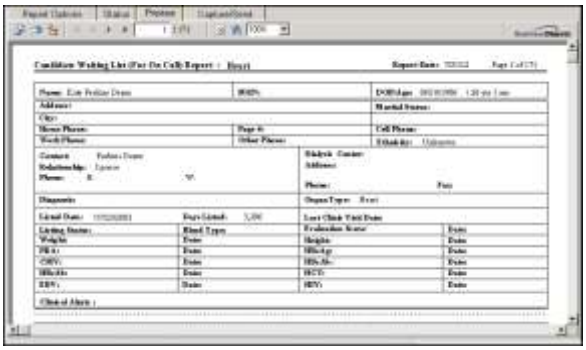
## Reports and Lists



Sites can print the patient's candidate listing record to send to the referring provider. From the **Patient** Master Menu, select **Reports,** select **Tx Phase Report,** select **Listing**.



To print the **Transplant On Call** Report from the **Tools** Master Menu, select **Reports**, then **Tx On Call Report**

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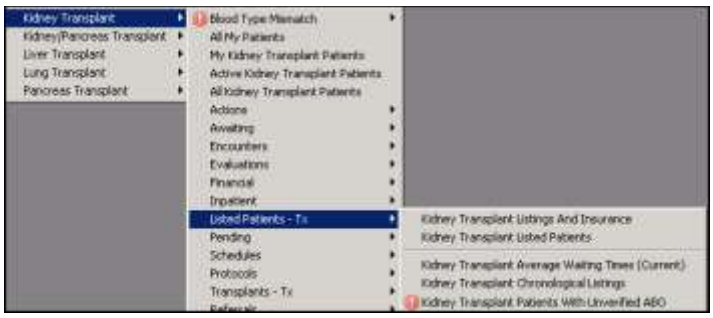


Listing Phase reports can be accessed from **Lists** Master Menu, select the desired program, then **Listed Patients-Tx**, then the desired report. The **Listed Patients** list is good to compare against your official UNOS waitlist.


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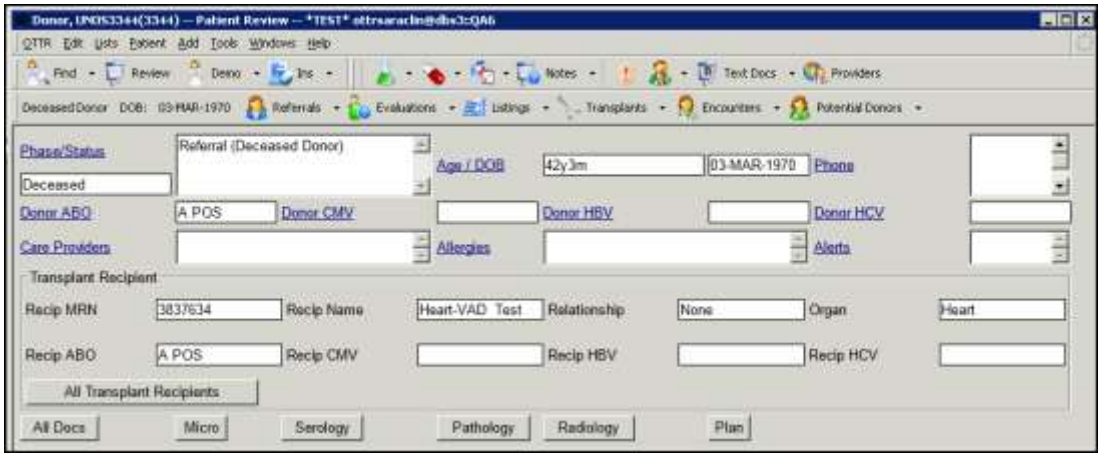
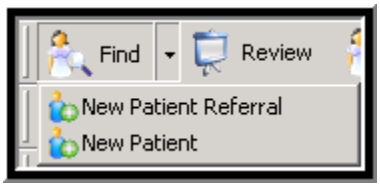
# Donors




In OTTR™, living donors go through the same referral and evaluation process as the recipient and are entered into the system using the **New Patient Referral** option. The Patient Review window functions the same way as the recipient review window but you'll notice some differences in the information that's displayed. Once a donor is linked to a recipient, you'll notice that some of the **Transplant Recipient** information displays on the **donor review** window.

By selecting the **All Transplant Recipients** button, you can view all transplants linked to that donor.




Since the deceased donors don't go through the same referral and evaluation processes, their information is entered in a different manner using the **New Patient** option from the **Find Patient** icon dropdown.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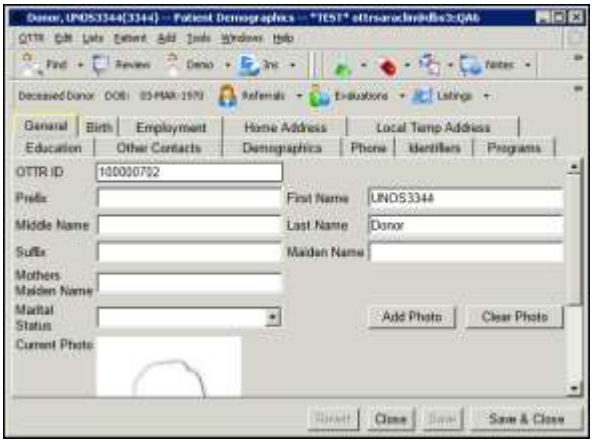
# Deceased Donor Demographics




## General Tab

When entering deceased donor information, only those fields your facility decides to populate should be completed.

The **OTTR ID** is an auto generated number. **DO NOT** enter anything in this field.

In this example, *Donor* was entered for the patient's last name and the *UNOS Donor Number* for the patient's first name.

## Birth Tab

If known, enter the donor's **Birth Date**.

If research is to be done in the future to determine if the donor's age factors into the success or failure of a transplant, this information must be captured.

It is recommended that information received in the donor packet be entered into the donor record.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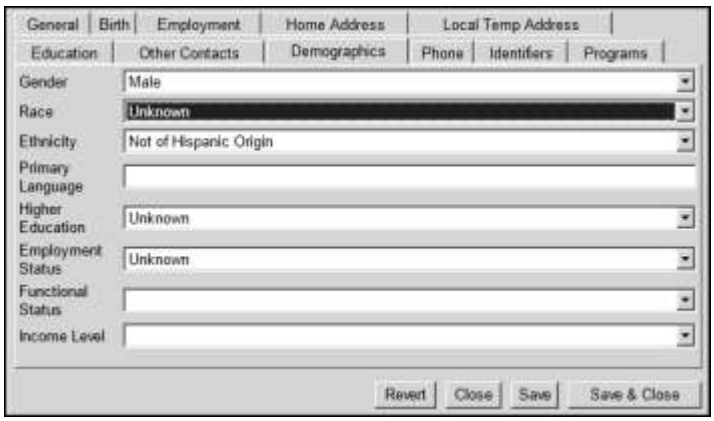
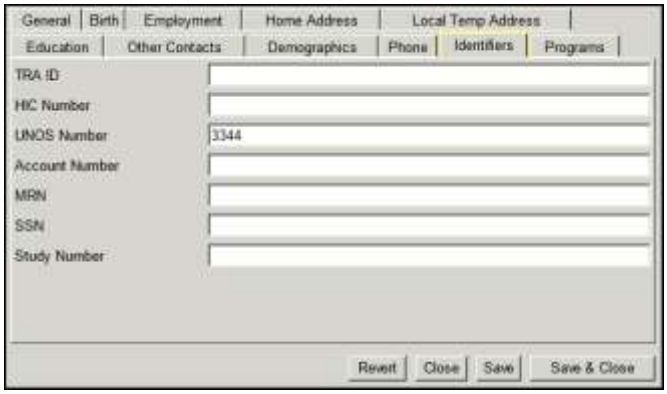



## Demographics Tab

If known, enter the donor's **Gender** and **Race**.

If research is to be done in the future to determine if the donor's gender or race factors into the success or failure of a transplant, this information must be captured.




## Identifiers Tab

Enter the deceased donor's **UNOS Number**.

Depending upon what has been entered into the donor record, you can later perform a search for the donor record using either the **Patient Name** or **UNOS Number**.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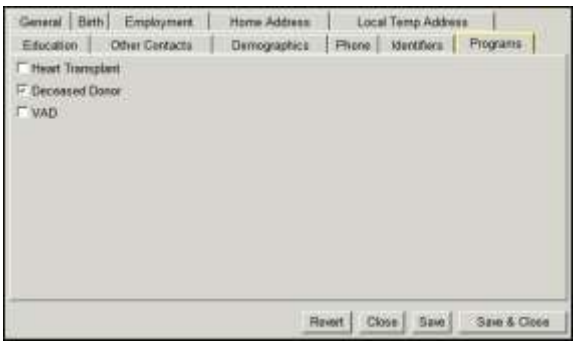


## Programs Tab

It's VERY IMPORTANT that you assign the patient to a **Program**. If you don't assign the program, the patient won't show up as a search result when using the **Find Patient** icon to perform a search.

Add the patient to the **Deceased Donor** program by placing a checkmark in the box provided. The living donor will be assigned to the *organ specific* **Living Donor** program.

Once you've entered the information in the donor demographics, your donor is technically entered into the OTTR™ system and can be linked to a recipient. You can continue and complete the **Death Info** and **Donor Info** if you have the donor packet available, or you can complete those sections at a later date.


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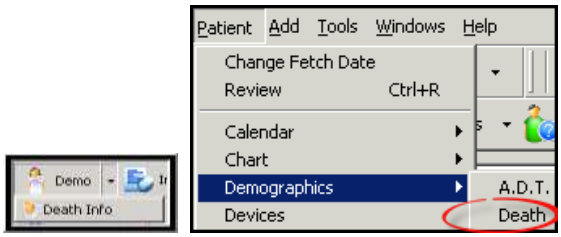
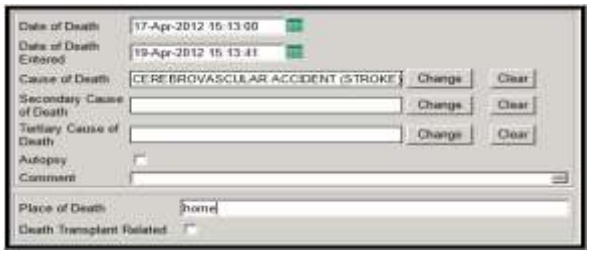
# Deceased Donor Death Info




## Death Information

Select **Death Info** from the **Demo** icon dropdown or from the **Patient** Master Menu, select **Demographics**, then **Death**.




Enter the **Date of Death** using the green calendar box. The **Date of Death Entered** will default to today's date but can be modified using the green calendar box.

**Cause of Death, Secondary Cause of Death, and Tertiary Cause of Death** are entered using the **Change** button next to the fields.

The **Autopsy** box can be used to indicate whether an autopsy was performed.

**Place of Death** is a free text entry if known.

This area is also used to record recipient death information so the **Death Transplant Related** box is more applicable for that situation.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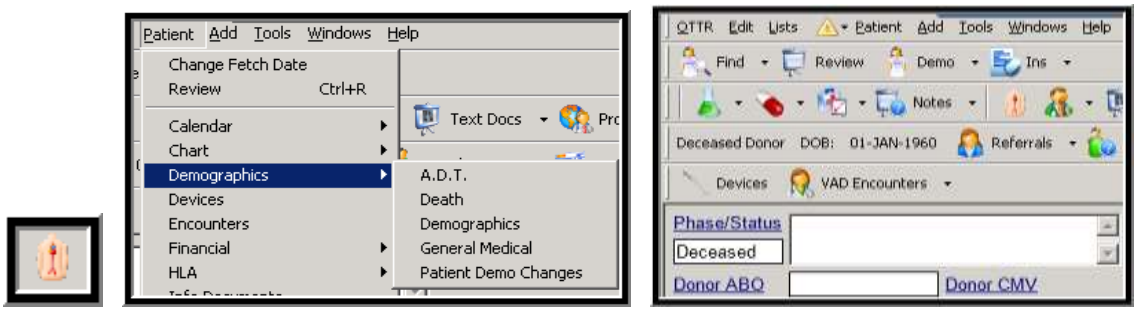
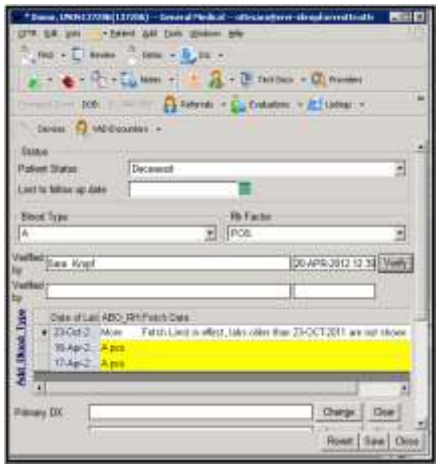
# Donor ABO




## Donor ABO

The donor's ABO should be entered in the **General Medical** window of the donor record using the **General Medical** Icon, the Donor ABO hyperlink from the patient review window, or from the **Patient** Master Menu, select **Demographics**, then **General Medical**.



In the **General Medical** window, add the ABO and Rh using the Add Blood Type hyperlink.

Once the blood type is entered, it will populate the **Blood Type** and **Rh Factor** fields above.

Blood type is verified by selecting the **Verify** button. The clinician's name along with today's date and time will populate in the field. You will not be able to edit the date and time once entered.

A 2nd verification is performed when another coordinator logs into the system, verifies the blood type and clicks the **Verify** button.

**Save and Close** when finished.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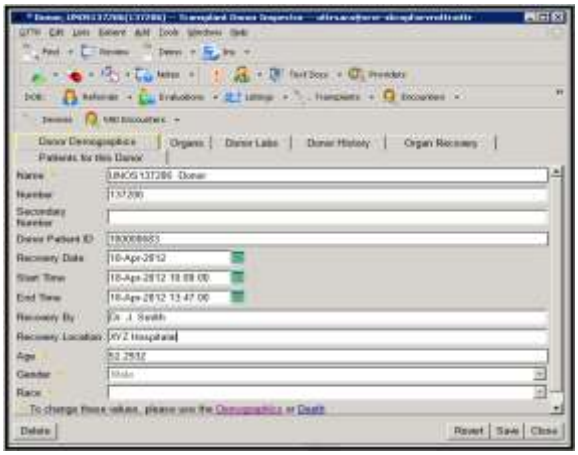
# Donor Info

## Donor Information - Donor Demographics Tab

Access the Donor Info , Transplant Donor Inspector window from the **Patient** Master Menu, select **Transplant**, then **Donor Info**



**Name** – The donor name auto-populates from patient demographics

**Number** – The UNOS number auto-populates from patient demographics

**Donor Patient ID** – The OTTR ID assigned to the patient auto-populates from patient demographics.

**Recovery Date, Start Time, End Time, Recovery By, Recovery Location** – Enter the information from the donor packet if known.

**Age, Gender, and Race** – auto-populates from the patient demographics. The age displays with a decimal in the event the donor is less than 1 year in age.

There are hyperlinks at the bottom of the window to allow access to the Demographics and Death windows to complete missing information.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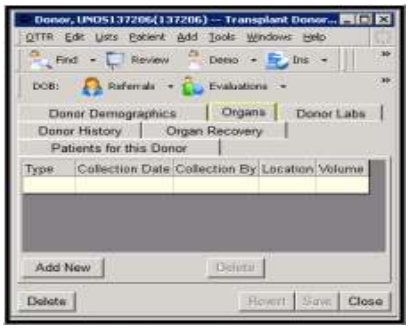


## Donor Information - Organs Tab

The Organs tab is intended for use in the Bone Marrow Transplant (BMT) Module and can be disregarded during solid organ transplant documentation

## Donor Information - Donor Labs Tab

Document the donor patient's lab results provided in the donor packet . This information may be used in future research and your facility will determine the fields they wish to capture.


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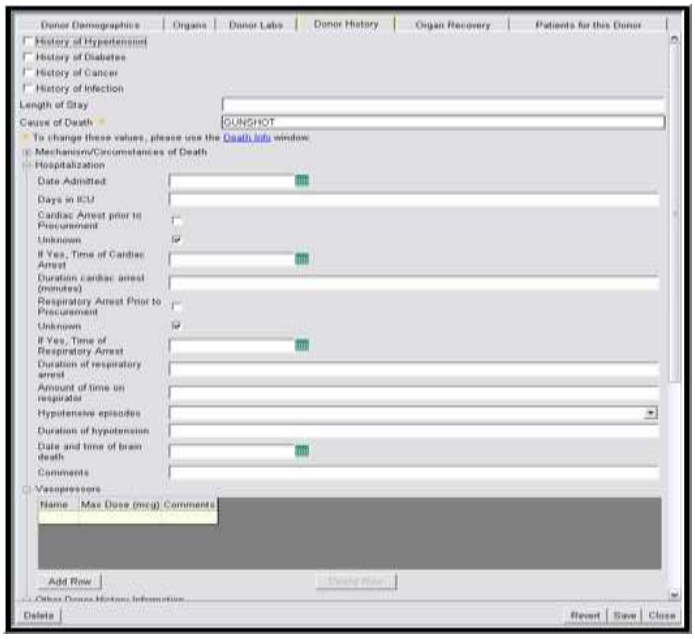


## Donor Info - Donor History Tab

Document the donor's history if known.

Vasopressor information can be added using the **Add Row** button. Once the information is entered, select **OK** to add that row of information.


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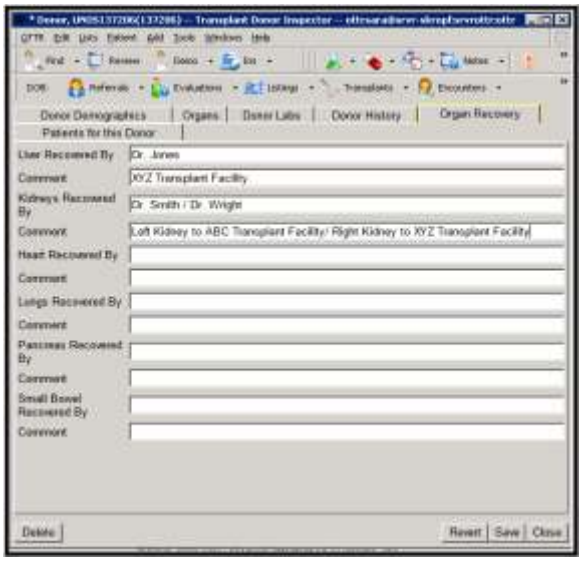


## Donor Info - Organ Recovery Tab

Complete the information for the type of organ recovered.

You can also document information regarding other organs removed from that donor if known. This may be useful post-transplant.

## Donor Info - Patients for this Donor

This window displays all recipients in your system who have been transplanted with organs from this donor patient but isn't populated until after a transplant event has been recorded in a recipient's record and the donor has been linked.


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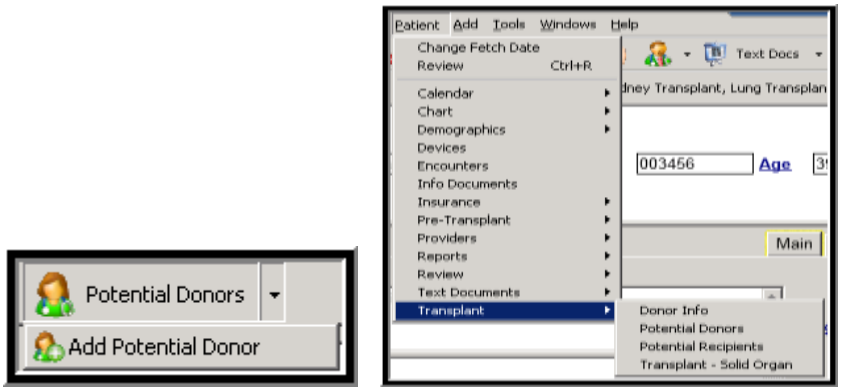
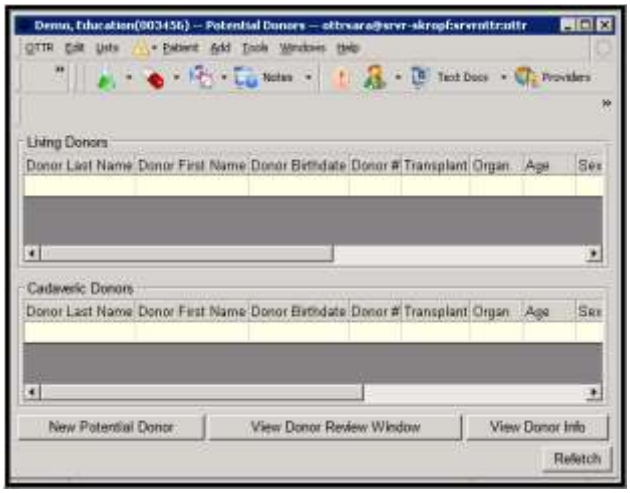
# Adding Potential Donors




While still in your **donor record** you can add potential recipients to the donor utilizing the **Patient** Master Menu, select **Transplant**, then **Potential Recipients**. You'll search for and add our potential recipient.

From your **recipient record**, you can add potential donor(s) for this recipient utilizing the **Add Potential Donor** from the **Potential Donors** icon dropdown or from the **Patient** Master Menu, select **Transplant**, then **Potential Donors**.




Select the **New Potential Donor** button in the bottom of the Potential Donors window.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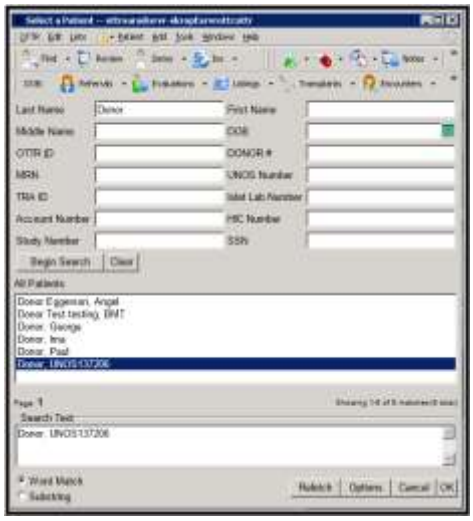
Next, select the **Donor Search** button in the New Potential Donor window.

Notice that this is done while in the recipient's record. Refer to the title bar to insure you are in the appropriate patient record.




Search for your living or deceased donor, highlight and click **OK** or highlight and double click to select.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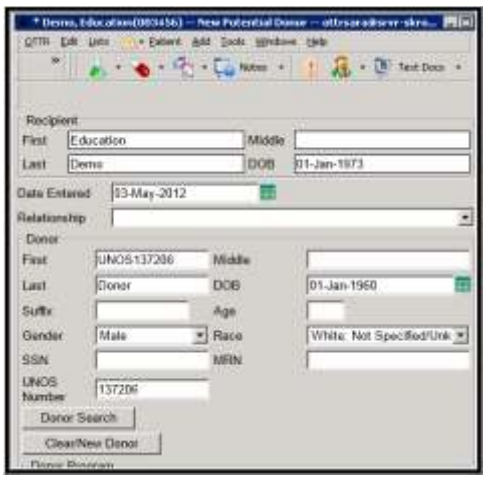


Your donor is now added as a **New Potential Donor** for this recipient.

## Viewing Potential Donors

Potential Donors can be viewed utilizing the **Potential Donors** icon or from the **Patient** Master Menu, select **Transplant,** then **Potential Donors.**


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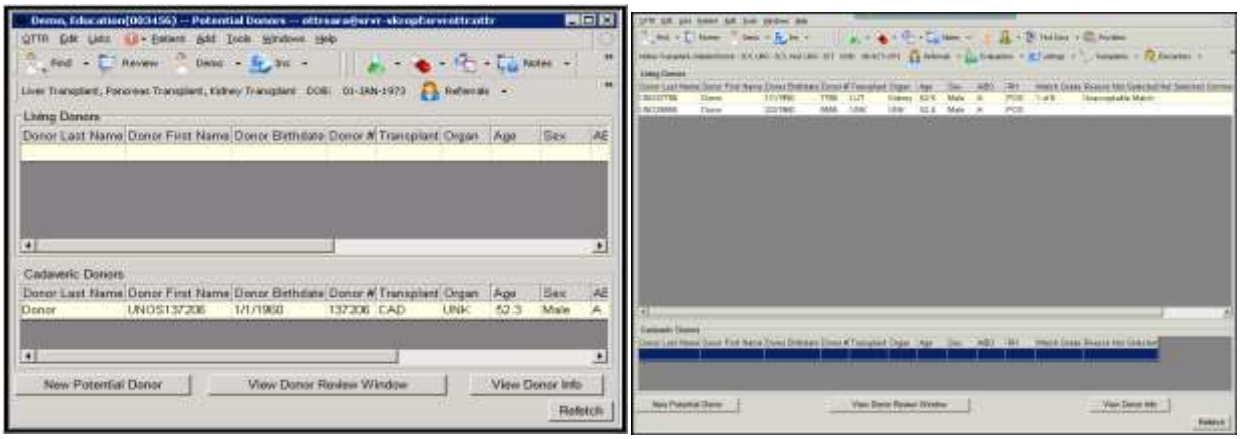
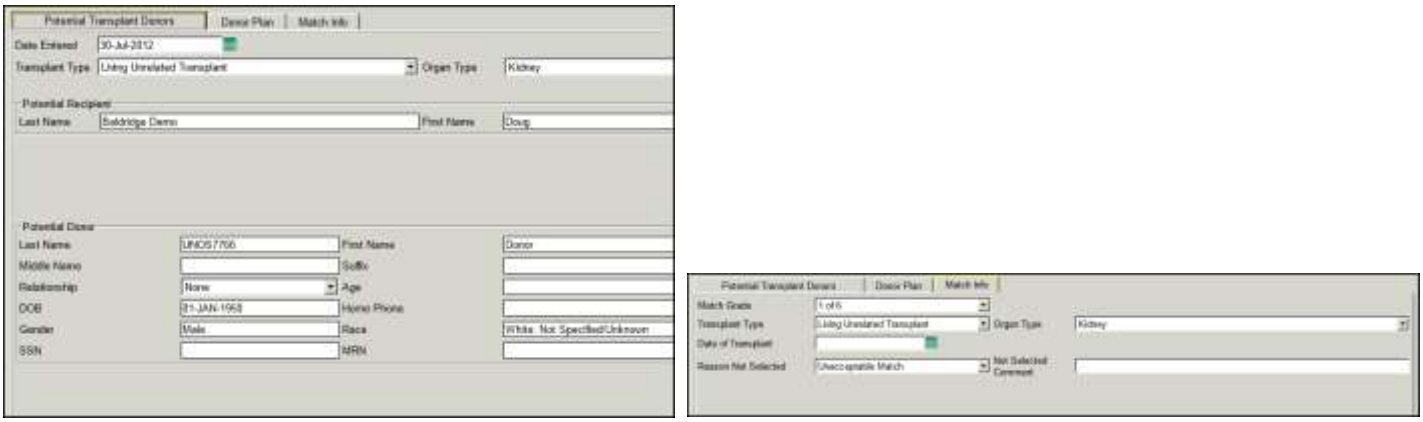



Living donors will populate the top of the window while deceased donors will populate the bottom of the widow.




Double click on a highlighted donor to view additional information.

The **Potential Transplant Donors** tab allows you to view the potential recipient along with basic donor information that auto-populates.

**Transplant Type** and **Organ Type** can be entered using the dropdowns next to those fields.

The **Donor Plan** tab allows you to add actions related to the donor.

The **Match Info** tab allows you to enter match grade information in addition to **Reasons Not Selected** if the donor isn't selected for transplant.

Once your potential donors are added, you'll link the actual transplant with the donor when you add the transplant event.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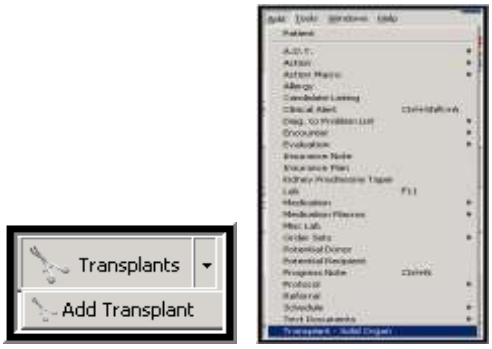
# Transplant

After you've added all potential donor(s) to OTTR™ for your recipient, you'll need to link the actual donor to your recipient and add the transplant event. Refer to the *Donor Management* section for detailed instructions on adding and managing donors.




A Transplant event is added to the recipient's record, using the **Add Transplant** option from the **Transplants** icon dropdown or from the **Add** Master Menu, select **Transplant-Solid Organ**.

The window titled **Select a donor for the new transplant record** will open.

All potential donors will be displayed. Select the appropriate donor by highlighting and double clicking on the appropriate donor or highlight and select **Ok**.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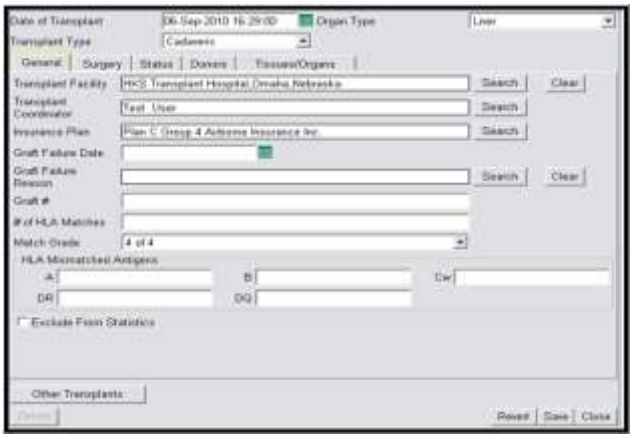
## General Tab




**Date of Transplant** – Click the green calendar to enter the transplant date.

**Organ Type** – Click the drop-down arrow to make a selection.

**Transplant Type** – Click the drop-down arrow to make a selection.

**Transplant Facility** – Click the **Search** button to select the facility where the transplant was performed.

**Transplant Coordinator** – Click the **Search** button to select the transplant coordinator's name.

**Insurance Plan**– Displays the patient's primary insurance provider at the time of the transplant. If no insurance provider is displayed, click the **Search** button to add the patient's primary insurance provider to the transplant record.

**Graft Failure Date**– Click on the green calendar to enter a date. If the transplant fails, the coordinator must enter the graft failure date within the original transplant record.

**Graft Failure Reason**– Click the **Search** button to select a graft failure reason.

**Graft #**– Enter the number for this type of graft.

**# of HLA Matches**– Enter the number of HLA matches completed.

**Match Grade**– Click on the drop-down arrow to make a selection.

**HLA Mismatched Antigens**– Enter the mismatched antigen information in the corresponding fields.

**Exclude From Statistics**– If checked, this transplant record will not be included in life table statistics.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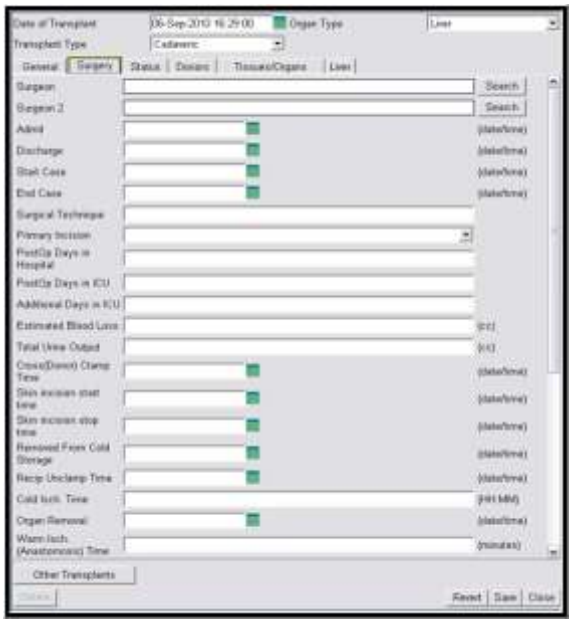
## Surgery Tab



**Surgeon** – Click the **Search** button to make a selection from the available transplant surgeons.

**Surgeon 2** – Click the **Search** button to make a selection.

**Admit** – Click the green calendar to enter the date and time of admission.

**Discharge** – Click the green calendar to enter the date and time of discharge.

**Start Case** – Click the green calendar to enter the date and time that the patient entered the OR room. (wheels in)

**End Case** – Click the green calendar to enter the date and time that the patient left the OR room. (wheels out)

**Surgical Technique** – Free text field.

**Primary Incision**– Click on the drop-down arrow to make a selection.

**Post Op Days in Hospital** – Enter the number of days the patient remained in the hospital post transplant.

**Post Op Days in ICU** – Enter the number of days the patient remained in the ICU.

**Additional Days in ICU**– Enter the number of additional days in the ICU outside of originally expected days.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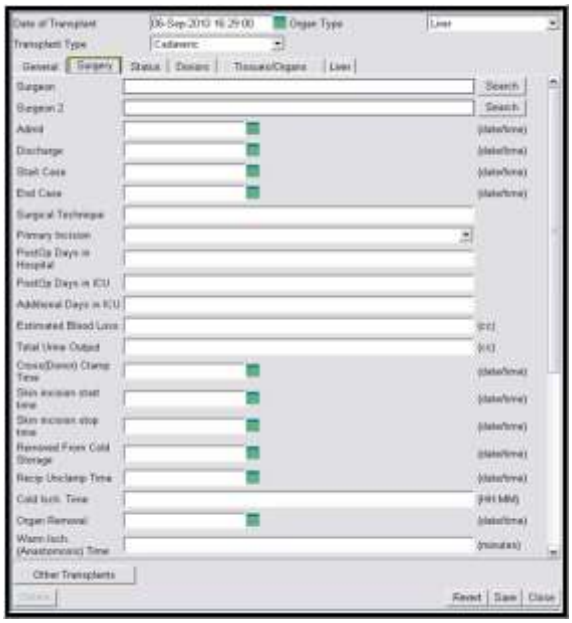
## Surgery Tab cont.



**Estimated Blood Loss** – Enter the amount of blood loss.

**Total Urine Output**– Enter total urine output amount.

**Cross (Donor) Clamp Time**– Click on the green calendar to enter a date and time.

**Skin incision start time**– Click on the green calendar to enter a date and time.

**Skin incision stop time**– Click on the green calendar to enter a date and time.

**Removed From Cold Storage**– Click on the green calendar to enter a date

**Recipient Unclamp Time**– Click on the green calendar to enter a date and time.

**Cold Ischemic Time**– This is a calculated field of 'cross clamp time' through the 'remove from cold storage' time.

**Organ Removal**– Click on the green calendar to enter a date and time.

**Warm Ischemic (Anastomosis) Time**– Calculated field of 'remove from cold storage' through 'recipient unclamp' time.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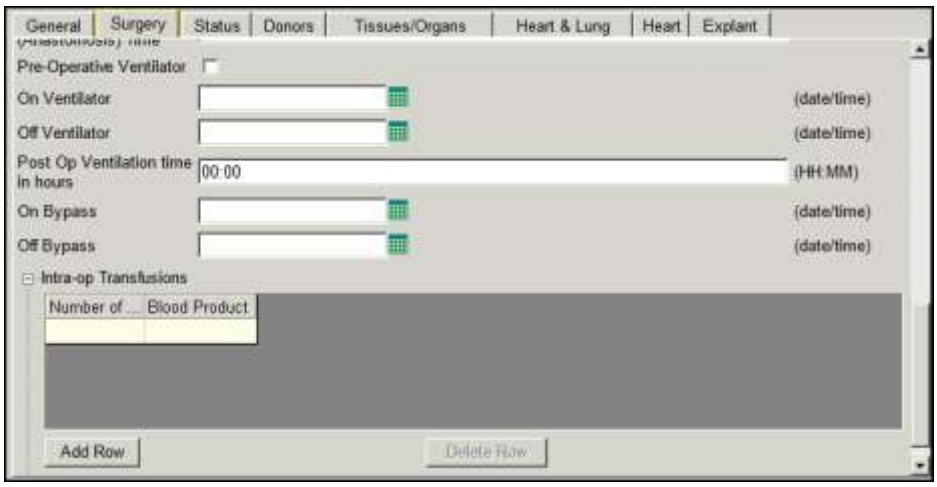



**Pre-Operative Ventilator** – Place a check mark if yes.

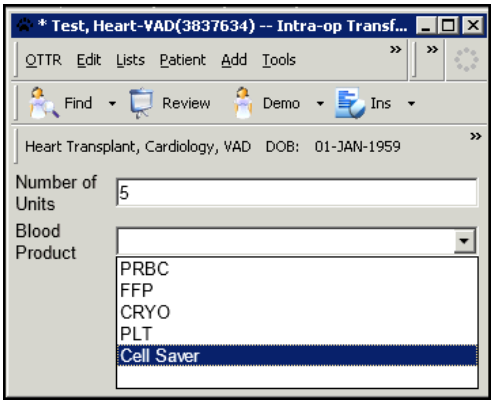
**On Ventilator**– Click on the green calendar to enter a date and time.

**Off Ventilator**– Click on the green calendar to enter a date and time.

**Post Op Ventilation time in hours**– This is a calculation of the 'On vent' time through the 'Off vent' time.

**On Bypass**– Click on the green calendar to enter a date and time.

**Off Bypass**– Click on the green calendar to enter a date and time.




**Intra-op Transfusions**– Click the **Add Row** button to enter the number of units and type of blood product. Click **OK** when finished. You can continue to make multiple entries using the **Add Row** feature.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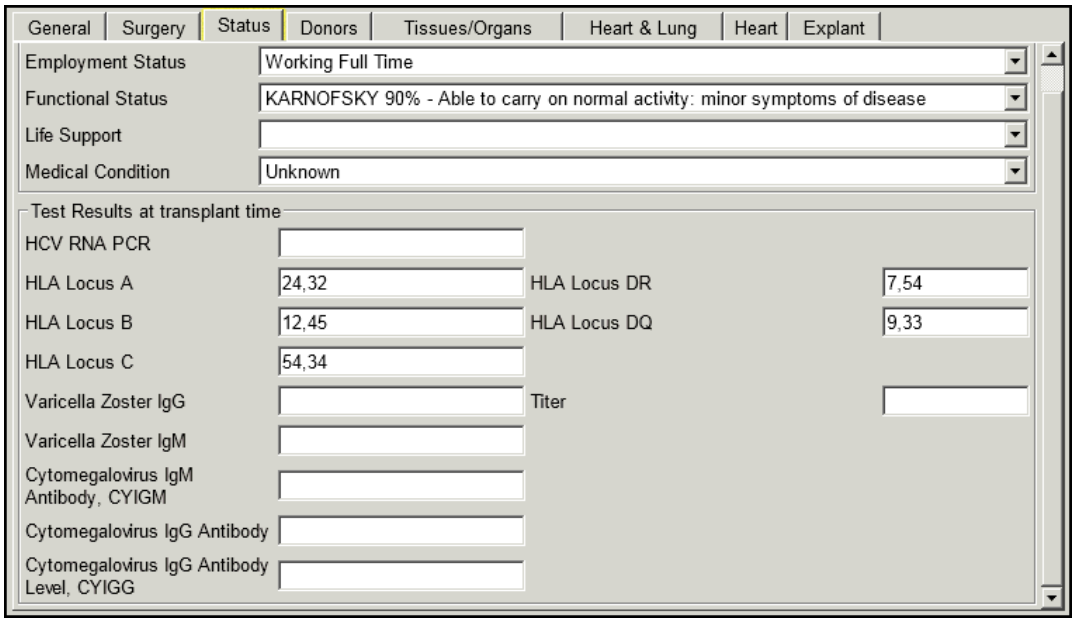
## Status Tab




**Employment Status**– Pulls information entered into patient demographics. You can modify or add a selection by clicking on the drop-down arrow.

**Functional Status**– Pulls information entered into patient demographics . You can modify or add a selection by clicking on the drop-down arrow.

**Life Support**– Click on the drop-down arrow to make a selection.

**Medical Condition**– Click on the drop-down arrow to make a selection.

**Test Results at transplant time** – Pulls lab results current for the patient at the time of transplant.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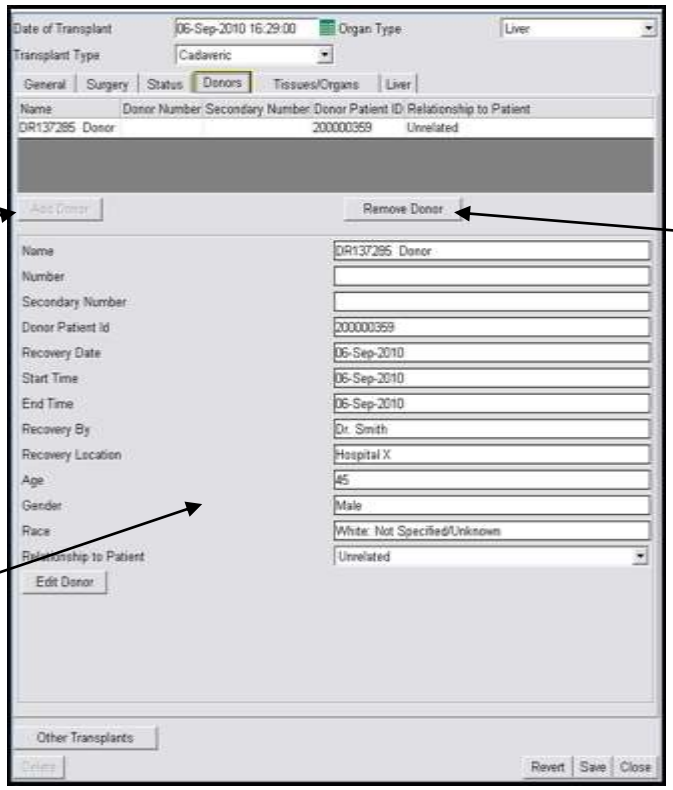
## Donors Tab




Click to Add a Donor if not previously linked

To remove a previously added donor, highlight the row and select Remove Donor

Displays information entered in the donor record.

When initially adding a transplant to the recipient record, the clinician can select and attach the donor patient for this transplant record. If selected, information entered in the donor's record displays in the linked fields.

If the donor isn't added when initially adding the transplant, the **Add Donor** button can be selected to choose from the list of potential donors.

**Name** – Displays the donor patient 's name.

**Number & Secondary Number** - Site defined but is usually the UNOS number.

**Donor Patient ID** – OTTR™ auto generated ID.

**Relationship to Patient** - The relationship to the patient displays here.

To modify or enter missing donor information select the **Edit Donor** button which opens the **Transplant Donor Inspector window**.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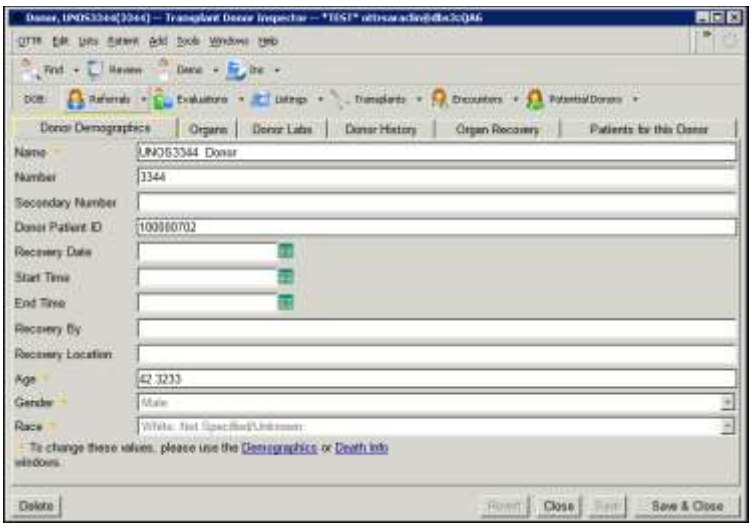
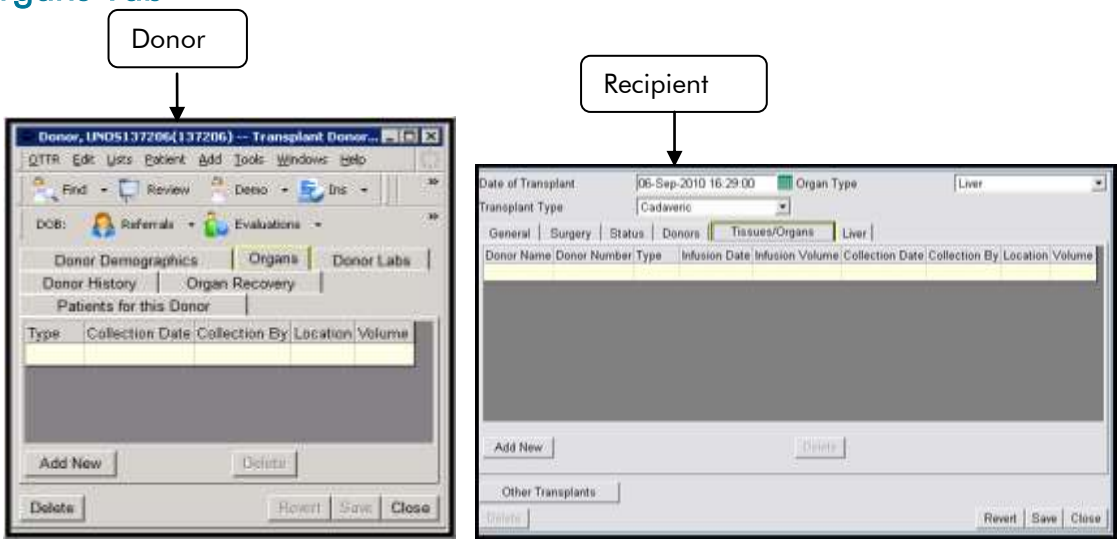



After entering information, select **Save & Close** to return to the recipient's record.

## Tissues/Organs Tab




The **Tissues/Organs** tab of the transplant event pulls information from the **Organs** tab of the **Transplant Donor Inspector** window on the donor side.

This tab is intended for use in the Bone Marrow Transplant (BMT) Module and can be disregarded when using for solid organ transplant documentation. Some sites do choose to use it to document the type of organ and location such as 'Left Kidney'. If used in this manner, the **Add New** button on the recipient side in the **Tissues/Organs** tab allows you to bring that information across into the record.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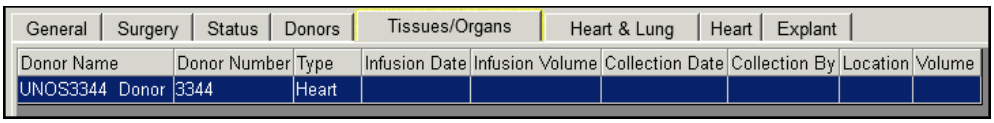
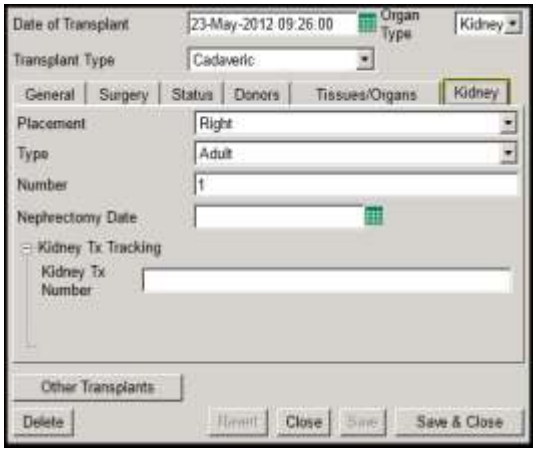
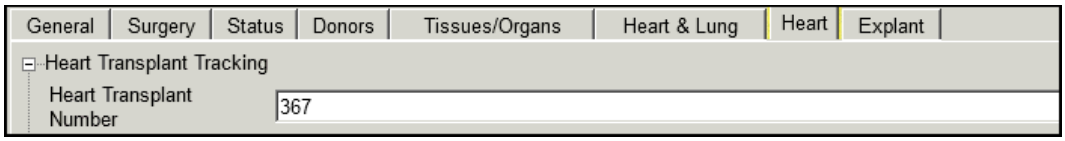



Above is an example showing the type of organ removed from the donor, and displaying in the recipient's transplant event.

## Additional Organ Tabs






Depending on the type of transplant performed, additional organ specific tabs will be available to document items specific to that type of transplant.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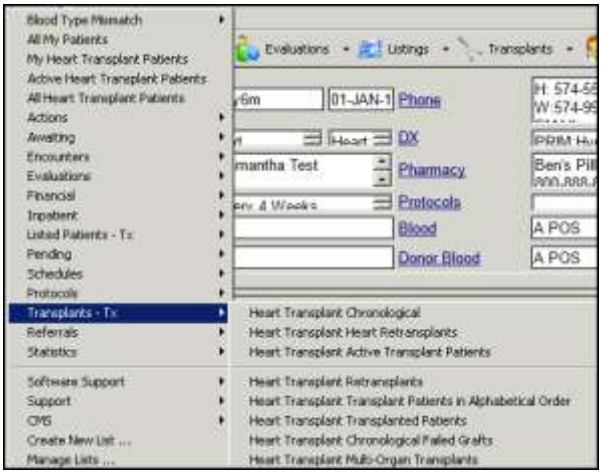
## Closing the Listing Record

When the **Save** button is selected while entering Transplant information, a pop up message will display asking if you want to close the candidate listing record.

If you select **Yes**, the listing record for the patient will be date, time stamped and ended with an **End Reason** of Transplanted.




The patient will now populate the appropriate Transplant Phase Lists accessed from the **Lists** Master Menu, select **Transplant-Tx**, then the desired list such as **Active Transplant Patients** list.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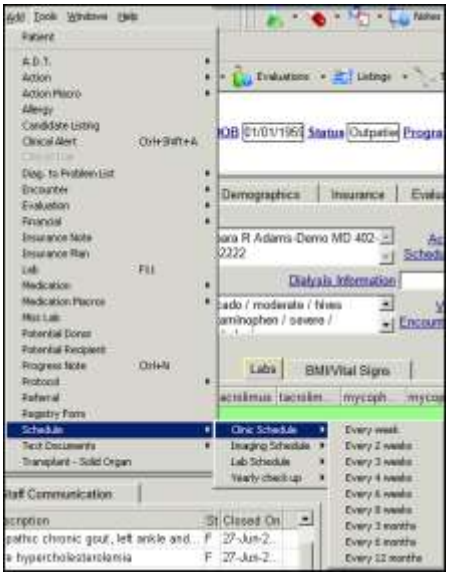
# Patient Schedules and Calendar



## Schedules

Schedules such as clinic, imaging, lab, and yearly check up schedules can be added to a patient record. To add a schedule, select the Add Schedules hyperlink or from the **Add** Master Menu, select **Schedule**, select the **type of schedule**, then the **frequency**.

* Test, Heart-VAD(3837634) -- Schedule -- *TEST* ottrsaraclin@dbs3::QA6
OTTR Edit Lists Patient Add Tools Windows Help
Find Review Demo Ins
DOB: Referrals Evaluations Listings Transplants
Start Date 26-Jul-2012
Patient Notified
End Date
Sync to last lab date
Schedule
Every 2 weeks
Adjust End Delete Edit Revert Close Save Save & Close

Enter the date you want the schedule to start in the **Start Date** field.

The **End Date** will be used at a later time when you want to end this schedule and is populated by clicking the **End** button in the bottom of the window.

After a schedule is active, the **Adjust** button can be used to activate the **Start Date** field to adjust the date.

Once you've notified the patient of the schedule, place a check in the **Patient Notified** box. The patient will fall on the **Schedules - Schedule Changes** list until marked notified.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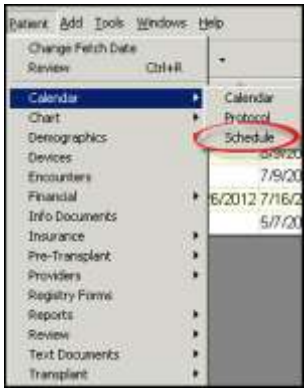
In this example a 2 week clinic schedule was selected but can be changed using the dropdown in the **Schedule** field.

In the case of a lab schedule, the **Sync to last lab date** will be active, allowing you to reset the next expected date for the system.



To view or manage schedules, select the Add Schedules hyperlink or from the **Patient** Master Menu, Select **Calendar**, then **Schedule.**

| Type | Schedule | Start Date | End Date | Next Expected | Last Expected | Last Data |
|---|---|---|---|---|---|---|
| Clinic Schedule | Every 2 weeks | 7/26/2012 | | 8/9/2012 | 7/25/2012 3:57:02 PM | |
| Yearly check up | Every 12 months | 7/9/2012 | | 7/9/2013 | 7/9/2012 9:05:00 AM | |
| Clinic Schedule | Every week | 7/9/2012 | 7/26/2012 | 7/16/2012 | 7/25/2012 3:57:02 PM | |
| Lab Schedule | Every 4 Weeks | 4/9/2012 | | 5/7/2012 | 3/9/2012 8:36:00 AM | |

All active schedules will display. To modify, adjust, or end a schedule, double click on the row of the schedule you want to open.

From the **Lists** Master Menu, select **Schedules** to access the following lists:

- **Overdue Schedules** - This list displays patients which have been assigned a schedule such as lab or clinic visits and the information (result or encounter) has not yet been entered into OTTR™. To be added to the list an expected schedule date must pass and no result entered. To be removed from the list the expected schedule date must be reset or the expected results must be entered.
- **All Active Schedules** - This list displays all patients which have an active schedule. A patient is added to the list when a schedule is added. The patient is removed from the list when the schedule end date is entered.

- **Schedule Changes** - This list displays patients which have had a schedule added to their record and they have not been marked notified. To be removed from the list the mark the Patient Notified check box must be checked in the schedule inspector.
- **Upcoming Events** - This list displays patients who have an expected schedule date in the future or on today's date. To be removed from the list date must pass or event completed.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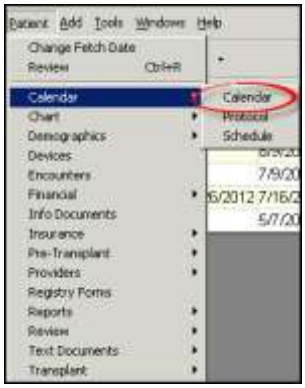
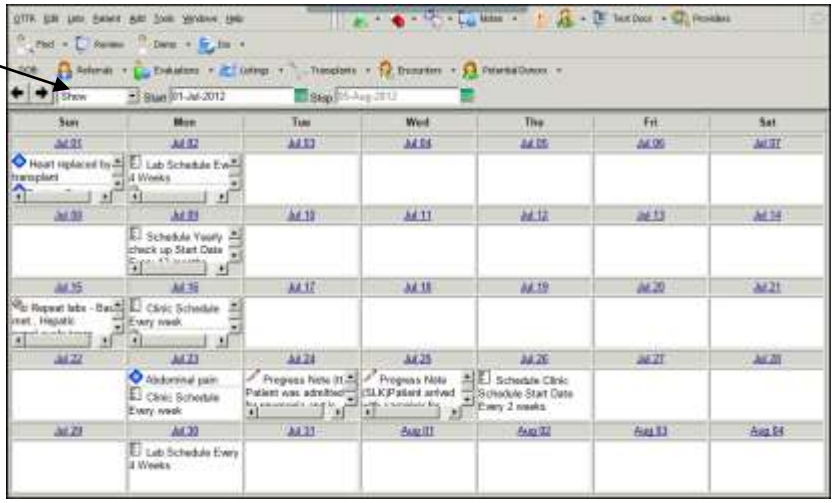



## Patient Calendar

To view a patient's calendar, from the **Patient** Master Menu, select **Calendar**, then **Calendar**

Change the view here.



The calendar can be used to match appointments with a date that the patient is already scheduled to be at the facility.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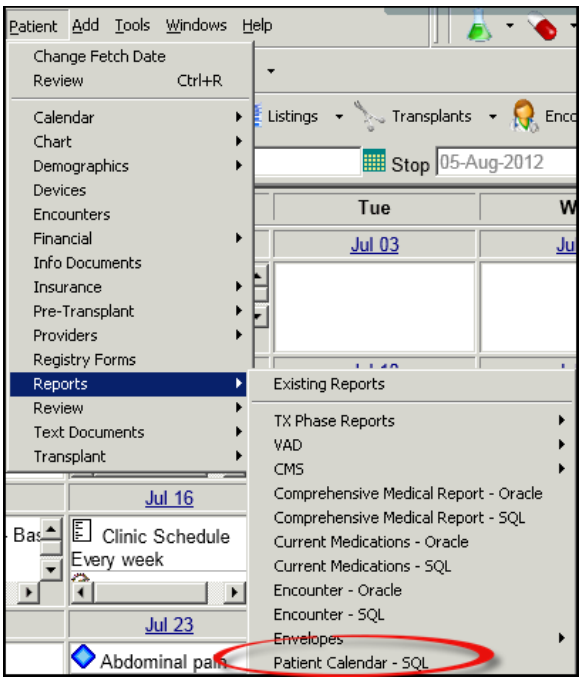


To print a copy of the calendar, from the **Patient** Master Menu, select **Reports**, then **Patient Calendar**.


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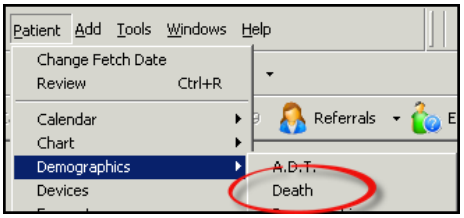
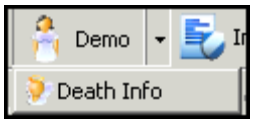
# Expired Patients




Death information for expired patients can be entered using the **Death Info** icon or from the Patient Master Menu, select **Demographics**, Select **Death**.

Enter the **Date of Death**. The **Date of Death Entered** should reflect the day you entered the death information. Use the **Change** buttons to select **Cause of Death**, **Secondary** and **Tertiary Cause of Death** if applicable. The **Clear** button clears the entry. If an autopsy was performed, but a check in the **Autopsy** box. Enter a comment or autopsy impression in the **Comment** field. Enter the **Place of Death** if known. If the cause of death was transplant related, place a check in the **Death Transplant Related** box.

**Save & Close** when finished.

**Note:** In the event that a patient expires, there may be active schedules, unscheduled actions, or pending results which will need to be either closed or reviewed.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# Supplemental Documents


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# Color Reference Chart

### MANUALLY ENTERED LABS

Not Yet Reviewed:

Lab Rule Violation:

Inpatient/Inpatient Elsewhere:

Outpatient Labs:

No "lab type" was selected at time of data entry:

### DIAGNOSIS

Tentative Preliminary:

Deleted/Not-Confirmed:

Verified Negative:

Confirmed:

Previous Medical History or Data Conversion:

Inactive:

### MEDICATIONS

Patient Not Yet Notified:

Active Medication:

Closed/Inactive Medication:

### ACTIONS

Not Scheduled:

Not Marked Done:

Urgent/ASAP/Next Available:

### INTERFACED LABS

Not Yet Reviewed:

Lab Rule Violation:

Inpatient Labs:

Outpatient Labs:

### ADT

Defines an unmatched OUT event (event that sets the patient status to outpatient), such as a Discharge even without an Admit event that matches.

Defines an unmatched IN event (events that start the patient stay) such, as an Admit event without a Discharge event that matches.

matched IN and OUT event, such as an Admit event with a matching Discharge event or Discharge event with a matching Admit event.


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# General Daily Workflow- Coordinators

- Check My Awaiting Coordinator Review List
    - Send appropriate items (actions) for physician review
    - Mark items as reviewed
    - Mark the actions as 'Done' for those items that you've just reviewed. Items can be marked 'Done' from the Patient Review window, or on the My Pending Actions List. *If any of the items are part of an active evaluation, be sure to put a short summary of the result in the comment section of the action
- Check My Pending Actions List and complete or follow up on remaining items due for the day.
    - The day prior to your Selection Committee meeting, sort your list to look for the scheduled Selection Committee action indicating your patient is ready to present.
    - Look for upcoming clinic appointment or initial visit actions to know who will be arriving for clinic so that their chart is updated.
- Check the Pending Medication Changes List and notify patient's of any medication changes.
- Check the Pending Evaluation Actions - Not Done
    - Look for items yet to be completed
    - Once all evaluation items are completed, add a Selection Committee action for that patient to indicate they are ready for presentation
- As items arrive for patients, update their records
    - Add any pertinent manual labs
    - Scan in documents
    - Prescription refills
- Check Overdue Schedules
    - Follow up with patient's regarding overdue lab or clinic schedules


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# General Daily Workflow - Transplant Assistants

- Check **My Pending Actions** List and complete or follow up on remaining items due for the day that are assigned to you
    - Look for upcoming clinic appointment or initial visit actions to know who will be arriving for clinic so that their chart is updated
    - Schedule outstanding tests or appointments
- Check the **Pending Actions - Unscheduled** and **Not Done** lists to follow up on items that aren't assigned directly to you but may need completed
- Check the **Pending Evaluation Actions - Unscheduled**
    - Schedule any unscheduled items
    - Once all evaluation items are completed, add a Selection Committee action for that patient to indicate they are ready for presentation
- Check the **Pending Evaluation Actions - Not Done**
    - Follow up with any patients who were due for scheduled testing or consults and you've yet to see results
- As items arrive for patients, update their records
    - Add any pertinent manual labs
    - Scan in documents
- Check **Overdue Schedules**
    - Follow up with patient's regarding overdue lab or clinic schedules
- When patient's arrive for clinic
    - Verify demographic information
    - Verify Allergies
    - Add Vital Signs, Height and Weight using the **Patient** master menu, select **Chart**, select **BSA Vitals**


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# Recommended Physician/Coordinator Review Process

Listed below is our recommended process for facilitating the communication that occurs during the coordinator and physician review process. We feel this process enhances patient safety and continuity of care. However, this is a recommended guideline and you'll need to discuss and adapt to meet your Transplant or Ventricular Assist Device Center's needs.

- The coordinators will review all of their items in their **My Awaiting Coordinator Review** List. All abnormal results are sent for physician review using the appropriate action for that abnormal issue. For normal results, the coordinator can choose the 'Lab Review' action. **Follow your center's policy for sending results for physician review as some center's will want physician's to review all items regardless of normal or abnormal result.

- To assign the particular action to a certain physician, the coordinator can open the action and assign it to the **responsible person** or physician.

- The physician's will review the **Awaiting Physician Review** list, and their **My Pending Actions** list if coordinators are assigning individual physician's as responsible.

- The physician will add the appropriate action for any additional testing or follow up that needs to be completed, which will fall on the coordinator's **My Pending Actions** list. If a medication change is made, they will NOT mark the patient as notified so that it falls on the **Pending Medication Changes** list.

- The physician review action will be **'marked done'** by the physician.

- The coordinator will review their **My Pending Actions** and **Medication Changes** lists, to schedule any testing, perform any follow up or notify the patient of any changes in care. The actions will be 'marked done' as appropriate.

**Note:** Any issues that need immediate attention and cannot wait 24 hours should be communicated through direct communication via phone call or face to face conversation for patient safety reasons.


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